REPORT OF THE HEALTH SERVICES REVIEW COMMITTEE

VOLUME I:
SUMMARY AND RECOMMENDATIONS

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HEALTH SERVICES REVIEW COMMITTEE

VOLUME I: SUMMARY AND RECOMMENDATIONS

November, 1985

Manitoba

Health

Health Services Commission
Research and Planning

308 Somerset Place
294 Portage Avenue
Winnipeg, Manitoba, CANADA
R3C 0B9

(204) 945-8599

November 15, 1985

The Honourable L. L. Desjardins
Minister of Health

Sir:

On behalf of the Committee members, I have the honour to submit the Report of the Health Services Review Committee.

Respectfully submitted,

David Pascoe
Chairman
Health Services Review Committee

ACKNOWLEDGEMENTS

The Report of the Health Services Review Committee represents thousands of hours of input from members of the fifteen sub-committees, recording secretaries and Manitoba Health Services Commission data processing staff.

The Committee joins to express its thanks to the sub-committees' recording secretaries who aided sub-committee work with formal minutes of all meetings and drafts of the sub-committee reports. The recording secretaries included the following staff:

Linda Bakken	- Manitoba Health Services Commission
Sean Drain	- Manitoba Health Services Commission
Donald Krack	- Manitoba Health Services Commission
Phyllis MacDonald	- Manitoba Health Services Commission
Ann Nemecek	- Manitoba Health Services Commission
Heather Payne	- Manitoba Health Services Commission
Norma Schwabe	- Manitoba Health Services Commission
Linda Webster	- Manitoba Health

A special thanks is extended to Lucienne Stadnyk who coordinated all Health Services Review Committee correspondence as well as revisions to the drafts of this Report.

HEALTH SERVICES REVIEW COMMITTEE MEMBERSHIP*

Lloyd C. Bartlett, M.D.	Manitoba Medical Association, Urban
Ted I. Bartman	Urban Non-Teaching Hospitals
Kenneth R. Brown, M.D.	College of Physicians and Surgeons of Manitoba
Frank J. DeCock	Manitoba Health Services Commission
William W. Devine	Rural Hospitals
Brian I. Gudmundson, Recording Secretary	Manitoba Health Services Commission and Manitoba Health
Gerry P. Hiebert**	Urban Teaching Hospitals
John M. Horne, Ph.D.	Faculty of Medicine
Nick K. Kalansky**	Urban Teaching Hospitals
Bryan W. Kirk, M.D.	Faculty of Medicine
Jack T. Litvack	Urban Teaching Hospitals
John H. McBeath, M.B.	Manitoba Health Services Commission
David W. Pascoe, Chairman	Manitoba Health Services Commission and Manitoba Health
Lawrence J. Stephen, M.D.	Manitoba Medical Association, Rural
Robyn M. Tamblyn**	Manitoba Association of Registered Nurses
John G. Wade, M.D.	Faculty of Medicine
Jack C. Wilt, M.D.**	Manitoba Health

HEALTH SERVICES REVIEW COMMITTEE FOOTNOTES

* Individual contributions do not necessarily reflect the position of the sponsoring agencies or institutions.

** Position change during the review process:

1) Gerry Hiebert resigned from the Health Sciences Centre, effective June 30, 1984, and was replaced by Nick Kalansky.

2) Nick Kalansky changed place of employment from the Health Sciences Centre to St. Boniface General Hospital, effective September 30, 1985.

3) Robyn Tamblyn changed place of employment from the Manitoba Association of Registered Nurses to St. Boniface General Hospital, effective November 7, 1984.

4) Dr. Jack Wilt retired from Manitoba Health effective September, 1985.

VOLUME I

HEALTH SERVICES REVIEW COMMITTEE

SUMMARY AND RECOMMENDATIONS

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PROLOGUE:

The Health Services Review Committee is aware that the Manitoba health care system is currently functioning under considerable stress. Health care facilities appear to be operating at close to capacity and there are continuing demands for services which have the potential to tax existing resources to the limit.

During many months of deliberation, the Health Services Review Committee has reviewed a considerable body of data including:

Health care utilization trends;
Population projections;
Health care funding;
Manitoba and Medicare report;
Adult Medical Patient Study; and,
Fifteen sub-committee reports.

While it was recognized that health care facilities fulfill a particular role and should be adequately resourced for that purpose, a common theme emerged to investigate viable alternatives to institutional care. All sub-committees eagerly responded to the challenge and made a genuine attempt to come to grips with the problems of increased demands upon existing fiscal and health care facility resources.

The present pressures on the system are exacerbated by a general reliance upon in-patient institutional resources. The development of the health system, since the advent of hospital insurance and Medicare, has emphasized acute care resources. Health care practitioners are often frustrated by their inability to implement viable alternatives to traditional modalities of care and cure. This reliance upon institutional resources manifests itself dramatically in the treatment and care of the elderly.

The Health Services Review Committee perceived that the province's ability to respond to health care delivery needs in Manitoba could be directed in one of several ways. These include:

1. More money for more of the same services; or,
2. Rationing of health care resources; or,
3. Develop innovative alternatives of treatment and prevention to the present emphasis on in-patient services.

The Health Services Review Committee concluded that the third option was the way to proceed. It merits support from all sections of the health care delivery system, including health providers (physicians, nurses, the Boards and administration), the public-at-large, and government. All sub-committees seriously addressed the issues and provided a number of recommendations and proposals in support of the third option, providing a cost effective continuum of accessible and appropriate health care services (ambulatory, institutional, and post-discharge supports).

The mandate from the Minister of Health to review Manitoba's health delivery network was to address innovative program ideas. All the work of the sub-committees and the Health Services Review Committee led them to concur that such emphasis is appropriate and timely for Manitoba. The recommendations from the sub-committees were considered seriously. All fifteen sub-committee chairmen are recognized leaders within their field. Thus, the review process was not an insulated, bureaucratic attempt at health care planning. Rather, it was an innovative exercise in consultation and deliberation.

To provide cost effective quality health care for Manitobans is a challenge for the entire health care system. It is proposed that the Minister continue to actively seek the assistance and counsel of the broadest constituency within the health care field in order to assure that the recommendations and proposals outlined in the Report can be translated into practical reality.

REVIEW PROCESS:

The Health Services Review Committee was formulated in December, 1983, with an invitation from the Minister of Health to individuals to participate in this ministerial review committee. This letter of invitation, which appears as Appendix A, established a framework within which Committee members were requested to participate.

The structure of the Committee was based on representation from a variety of health care segments. These included fifteen representatives from:

The College of Physicians and Surgeons of Manitoba;
Manitoba Association of Registered Nurses;
Manitoba Health;
Manitoba Health Services Commission;
Manitoba Medical Association, (Rural and Urban);
Rural Hospitals;
Faculty of Medicine, (University of Manitoba);
Urban Non-Teaching Hospitals; and,
Urban Teaching Hospitals.

This broad constituency provided a balance between institutional and organizational forces and crossed the boundaries of educational, funding, and service concerns.

The first meeting of the Health Services Review Committee was convened in February, 1984, at which time the Committee defined its work according to four broad topics. These topics were:

1) Areas which required further investigation;
2) The possible establishment of sub-committees to undertake studies on behalf of the Health Services Review Committee;
3) The process by which sub-committee reports would be received; and,
4) The form in which the Committee's work would be presented to the Minister of Health.

At subsequent meetings, the Health Services Review Committee refined its task to include four objectives. Thus, the terms of reference for the Health Services Review Committee were adopted by the Committee members and are listed as follows:

To identify major cost areas and explore consolidation;
To look for alternatives to in-patient services (e.g. - more ambulatory care);
To review current bed allocation and utilization; and,
To review criteria of hospital admissions in both urban and rural hospitals.

The Committee chose, as its vehicle of investigation, the formulation of sub-committees which were tasked to undertake specific investigations on behalf of the Health Services Review Committee. Areas of investigation were selected according to pressing issues of the day combined with those areas which presently consume a large majority of hospital days and medical services. The area of mental illness was not included under the review of the Health Services Review Committee as this had previously been reviewed with a report being tabled with the Minister of Health entitled "Mental Health Services In Manitoba, A Review and Recommendations" September, 1983.

The Health Services Review Committee thus commissioned fifteen sub-committees which reviewed the following areas:

Administrative Impacts;
Cardiovascular;
Community Health;
Critical Care;
Elderly;
Emergency;
Gastrointestinal;
Indian Health Services;
Not-For-Admission Surgery;
Obstetrics;
Oncology;
Out-Patient Medical Services;
Pediatrics;
Respiratory; and,
Terminal Illness.

During the working time of the Committee, one other review had been commissioned by the Manitoba Health Services Commission. This was a review of ophthalmology services. Although this report was not commissioned by the Health Services Review Committee, it was reviewed within the context of the overall scope of the Committee's activities.

The work of the sub-committees began with the appointment of chairmen. Chairmen were requested to prepare a membership list which required ratification by the Health Services Review Committee. In broad terms, the sub-committee's membership was constituted to balance medical input from both rural and urban practitioners, input from nursing representatives and such allied health specialists as were appropriate to the work of individual committees. Support was provided to the sub-committees by representatives of the Manitoba Health Services Commission and Manitoba Health (formerly referred to as the Department of Health). These staff members were responsible for scheduling meetings, preparing minutes, and facilitating special data runs of Manitoba Health Services Commission hospital and medical statistics. In order to provide a linkage between the Health Services Review Committee and the sub-committees, at least one member of the Health Services Review Committee was appointed as a liaison with the fifteen commissioned sub-committees. All sub-committees were supported by unique data runs of the Manitoba Health Services Commission hospital and medical statistics. Membership of the fifteen sub-committees is attached as Appendix B.

In order to provide each sub-committee chairman with an introduction to the context of the review process, a meeting was convened with the Minister of Health at which time information was presented to sub-committee chairmen. This meeting was held in June, 1984, and the letter of introduction from the Minister of Health to sub-committee chairmen is attached as Appendix C.

During the time that the Health Services Review Committee had commissioned the fifteen sub-committee reports and the tabling of these reports with the Committee, work was done to review existing information prepared by the Manitoba Health Services Commission and relevant studies which were undertaken or were currently underway at the time of the review process. The economic situation of the Province of Manitoba was presented for review by Committee members, as was general information regarding the organization of health care services in Manitoba and the trends of health service utilization and cost escalation experienced during the previous decade.

During the 1980's, the economic situation in Manitoba was less volatile than other Western Canadian provinces due to Manitoba's diversified economic base. This diversification provided Manitoba with greater resistance against the forces of recession. In 1982, Canada experienced a negative growth rate of 4.6% of the gross national product, while Manitoba experienced a negative growth rate of 2.9% of the gross domestic product. During this time unemployment in Manitoba stabilized somewhat and at the beginning of the work of the Health Services Review Committee Manitoba registered an unemployment rate of 9.4% compared to the Canadian average of 12.3%. When the Committee began its activities in February, 1984, the consumer price index for Winnipeg registered a 4.8% increase during the previous 12 months while the experience across the country was 5.5%. From June, 1981 to November, 1982, there was a net increase of 2,000 jobs registered within Manitoba. Although Manitoba fared relatively well during the period of the recession in the early 1980's, the debt of the Province of Manitoba continued to rise. The 1982 debt load for Manitoba on a per capita basis was the third highest in the country next to New Brunswick and Newfoundland. In 1982/83, 5% of the provincial budget was used to service the debt load while in 1983/84, that figure had risen to 9%.

This background information, provided for the benefit of the Health Services Review Committee, was interfaced with a Statistics Canada population study for the upcoming decade which projects a modest increase in the number of total residents in Manitoba. It is expected that between 1984 and 1995, Manitoba can expect a population increase of approximately 100,000 persons. Within this global increase, however, are three factors which were of interest to the Health Services Review Committee. The first factor included a rise in the proportion of individuals who are 65 years of age or older. By 1995 it is estimated that the elderly population will rise to 14% from 12% currently. The second factor of population change indicated a decrease of younger individuals, aged 0-14, from 22.6% to 19.8% by 1995. The third factor of population change was an anticipated decrease in the proportion of women of child bearing age as well as a slight decrease in the fertility rate.

In order to provide the members of the Health Services Review Committee with a historical review of health care utilization and expenditures, information was presented with regard to the budget of the Manitoba Health Services Commission from 1971 to 1981/82. Attention was focused on the budget of the Manitoba Health Services Commission and not on Manitoba Health because of the difficulty of attributing departmental expenditures according to programmatic commitments. The budget of the Manitoba Health Services Commission over this period of time rose at an average rate of 12.98% per year for ten years. After adjusting for inflationary trends, the budget of the Manitoba Health Services Commission grew at a real rate of 3% per year for a period of ten years. Thus, health care expenditures in Manitoba were relatively well buffered against the general trends of the recession.

HEALTH SYSTEM CONCERNS:

The Health Services Review Committee received several informational items which provided a pessimistic forecast for the future of health services in Manitoba. Such items included a fiscal forecast for Manitoba, the Winnipeg Adult Medical Patient Study, and the report entitled "Manitoba and Medicare 1971 to the Present". Each in their own way, suggested that the scenario of "business as usual" for the health industry in Manitoba was not feasible. The growth in health care expenditures outstripped inflation by 3% per year throughout the decade of the 1970's. Continued growth at this rate was considered to be difficult to sustain in the long run.

The fiscal forecast for Manitoba gives rise to concerns. The existing debt load is now calculated at approximately $7,000 per capita and may increase in the near future. The credit rating of the province has been subject to increasing pressures arising from the size of the debt load relative to Manitoba's revenues. The expenditures of the health industry are significant because they comprise approximately one-third of the province's expenditures. The annual increases during the last decade have far outstripped the growth of the gross domestic product, which is an indicator of the public's ability to pay. The existing health care system encourages over utilization of in-patient hospital services. During the last decade the cost per patient day in public general hospitals in Manitoba had increased by 84% in constant dollars. Two major reasons for Manitoba's significant increase in general hospital costs are an increase in hours per patient day and an increase in the non-wage inputs. One factor in this increase could be attributed to an increase in the elderly population, giving rise to greater demands for service provision.

Another indicator of problems with existing health services was the perceived shortage of acute care beds in Winnipeg. The Winnipeg Adult Medical Patient Study was undertaken to review the utilization of beds by adult medical patients. It was reported to the Health Services Review Committee that at the time of the study, 620 medical patients or 58% of those surveyed could probably have been discharged from hospital had additional community support services been available. The study was based on an acuity classification of patients and surveyed all Winnipeg hospitals' adult medical patients. The findings of this study and other information presented to the Health Service Review Committee led the Committee to the conclusion that the bed supply of Winnipeg hospitals is sufficient to meet the needs if additional non-bed-linked and community support services are made available.

A further indication of difficulties was the report entitled "Manitoba and Medicare 1971 to the Present". The general finding of this report was that the health care system demonstrated great flexibility to expand with increasing numbers of physicians relative to a given population base. The report documented that the supply of physicians relative to population had increased by 25% in Manitoba during the last decade. The Winnipeg physician supply increased at the fastest rate in the province. The report suggested that the number of doctors seen by the patient, called "patient commonality", had gone up drastically in the last decade. Besides the same number of patients being seen by more doctors, the hospital utilization of patient days per 1,000 population had decreased slightly to 1,470 per 1,000 population in 1981. It was suggested that such hospital utilization should be reexamined in light of lower utilization patterns in other jurisdictions (e.g. - several health maintenance organizations in the United States). This report did not provide a prescription for change, but indicated that service availability and service efficiencies should be considered carefully.

Presented with such cautions, the Health Services Review Committee concluded that a prescription of more funding to increase the same type of health services was neither feasible nor advisable. The "business as usual" scenario for the health industry was not a viable solution given Manitoba's debt load and competition for its service expenditures. The Health Services Review Committee further rejected the concept of service rationing. Restricted access to health services was not supported. The focus of the Health Services Review Committee turned towards exploration of alternate types of service delivery for treatment and prevention which could provide appropriate types of care within the limits of defined economic constraints.

HEALTH SYSTEM CHANGE:

The Health Services Review Committee recognized that several significant and interrelated changes are required for Manitoba's health care system. The scope of these changes is large. Any approach at piecemeal adjustments to the system was seen as an inadequate solution to cope with the demands of health care in the future.

It was underscored by the Health Services Review Committee that no health program operates in isolation. Recognition of the interaction and dependency between the components of the health care system was deemed mandatory to meet the level of health care demands projected for the next decade.

The Health Services Review Committee recognized that a number of variables in program funding should be monitored simultaneously. Such emphasis was shared in the out-patient sub-committee report which noted the interrelationship in the following recommendation:

> The average length of stay for in-patients could also be reduced with greater availability of ambulatory services such as:
>
> 1. preoperative evaluation and treatment of patients requiring surgery;
> 2. postoperative care and supervision allowing earlier discharge from hospital following surgery;
> 3. ongoing provision of medical treatment initiated in hospital allowing earlier discharge of medical patients; and
> 4. out-patient rehabilitation programs.

Given each of the above variables, the Health Services Review Committee considered what the overall effect on the health care system would be. Given ambulatory pre-operative and post-operative evaluations, along with earlier discharge and constant occupancy rate of acute beds, the operating costs of the existing acute beds will actually rise. Also, because the duration of stay would be shorter, the number of patients served per bed would increase. Providing indications for treatment remain unchanged, waiting lists would likely decline and the pressure for more acute beds would be diminished. Thus, a major saving on associated operating costs of new beds would be achieved as well as a saving on capital costs.

This is clearly an oversimplification because it only addresses a few of the variables in the equation. The Health Services Review Committee cautioned that the interrelationships of service supply and patient demand be examined closely. Without the community-based program for supported independence of the elderly, and without proper utilization of personal care homes and respite beds, the freed up acute beds could become occupied by a greater proportion of elderly patients awaiting placement to a facility other than an acute hospital.

If freed up acute care beds were to be filled by an increasing proportion of elderly patients, the efforts of improved ambulatory pre-operative and post-operative evaluation and treatment would be lost. The Health Services Review Committee cautioned that such variables be incorporated into the equation so that this does not occur. Any component of the health care delivery system under stress cannot be relieved without transfer of patient demands to other components of the health care industry.

The Health Services Review Committee recognized the need for transitional funding to accomplish the proposed change for the health care system. Such funding was described as necessary in the short-term to demonstrate to the public that forms of alternative ambulatory care were appropriate and accessible. The short-term benefit to Manitoba would be the demonstration that the growth of health expenditures of the past decade could be constrained. Appropriate forms of new service in addition to existing services would be available. If forms of service delivery were demonstrated as adequate for demands, then the long-term benefit for Manitoba would be that substitution of service could occur.

HEALTH SERVICES REVIEW COMMITTEE RECOMMENDATIONS:

The Health Services Review Committee emphasized that the health system develop innovative alternatives of treatment and prevention to replace the present emphasis on in-patient services. Also, the Committee emphasized that efficiencies of existing services should be continually monitored to ensure proper utilization. Effective institutional admission and discharge committees, adequate ambulatory services and adequate community-based services are all necessary for the support of other interrelated components of the health care system. The Health Services Review Committee recognized that funding incentives would require change to provide appropriate emphasis for each of the various types of health care service.

Specific recommendations of the Health Services Review Committee are listed in Volume II of the Health Services Review Committee Report. Each sub-committee recommendation is provided with a disposition by the Health Services Review Committee (e.g. - approve or reject). All recommendations have been grouped according to the following issues:

1. Improvement of current services.
2. Cost effective alternatives.
3. System reorganization.
4. Communication.
5. Information required.
6. Policy review and development.
7. Demonstration projects.
8. Phase-out or close a program.
9. Endorsement of present policy/practise.

The Health Services Review Committee endorsed a large number of recommendations presented by each of the sub-committees. While several improvements in current services were supported, the emphasis for change was for cost effective alternatives.

In the short-term, the Minister of Health also tasked the Health Services Review Committee to indicate its priority for utilization of $17.5 million capital expenditures to address current Winnipeg health facility perceived bed shortages. Specifically, the Minister asked the Committee to consider the following problems:

A. Examine small urban hospitals as being viable.
B. Examine personal care home waiting lists.
C. Examine possible requirements for additional extended treatment beds.

The request to the Committee focused upon short-term means to allow the movement of patients to the most appropriate level of care and to consider the substitution of ambulatory care services where appropriate.

The Health Services Review Committee had completed most all of its work when presented with this additional task. Committee members had reviewed the sub-committee reports and had been presented with up-to-date information on the Winnipeg Adult Medical Patient Study and received the report released entitled "Manitoba and Medicare 1971 to the Present". Within this context, the Health Services Review Committee was informed of Cabinet's intent to provide $17.5 million capital funding to relieve the perceived stress upon Winnipeg health facilities.

The fund of $17.5 million capital was derived from an estimate of the construction of 150 beds which would be spread amongst acute, extended and personal care home facilities. It was recognized that such capital funding implied approximately $9.6 million annual operating funding.

The Health Services Review Committee reached unanimous agreement that the one time occurring capital funds be allocated in a manner different from that established in the Manitoba Health Services Commission five-year capital program (which was only bed-linked). Specifically, the Health Services Review Committee recommended to the Minister that the capital sum of $17.5 million not be used for the construction of any additional acute care beds in the City of Winnipeg at this time. The Committee unanimously recommended that the Minister allocate a sum of $8.5 million from the capital fund to construct 80-90 additional extended treatment beds out of which there would be established a viable unit for respite care.

The future annual operating and capital costs required to support the construction of this number of beds had been estimated at $5.5 million. In accepting an upper limit of $9.6 million annual operating costs for the previously established construction program to build an additional 150 acute care beds, the Health Services Review Committee unanimously recommended that the Minister consider alternative uses for the unallocated $4.1 million annual operating costs. The proposed allocation of such funding was defined as follows:

Program Components	Program Description	Capital Cost*	Future Annual Operating And Capital Cost
Health Facility Beds	80-90 Extended Treatment Beds (some for respite)	$ 8.5M	$ 5.5M
Multi-factorial Program	NFA surgery, Ambulatory Medical Care, and Out-Patient Diagnotic Services	7.0M	2.1M
	Community-based Services	0	2.0M
Demonstration Projects	One time limited services requiring evaluation	2.0M	0
Total		$17.5M	$ 9.6M

* Defined as if paid in one year. Such costs are, however, amortized over 25 years through Manitoba Health Services Commission funding.

The Committee recommended that the Minister establish non-institutional bed-linked programs which would be of a multi-factorial ambulatory care nature. Specifically, this ambulatory care program would include:

A. Admission screening and discharge planning.
B. Not-for-admission surgery.
C. Ambulatory care medical services.
D. Out-patient diagnostic services.
E. Continuing Care Program expansion.
F. Elderly day care.

The Committee urged a shift in focus to the construction of extended treatment beds and the required ambulatory services to provide appropriate care and reduce the demand upon acute hospitals. Expansion of the acute hospital bed supply was seen to be insufficient to satisfy the service demand and inappropriate for the types of services seen to be more urgently required. The Health Services Review Committee recommended that no additional personal care home beds be constructed at this time. The addition of more personal care home beds was seen to be inadequate because of the 4-6 year average length of stay per resident. The projected impact upon acute beds with increased personal care home beds was seen to be minimal.

The recommendations of the Health Services Review Committee were developed as a pragmatic response to the variety of demands upon Manitoba's health care system.

APPENDIX A

MANITOBA

MINISTER OF HEALTH
MINISTRE DE LA SANTÉ

WINNIPEG, MANITOBA
R3C 5R8

FEB 3 1984

Dear

I have requested David Pascoe, Director of the Research and Planning Directorate, to chair a Health Services Review Committee. The Review Committee will be established in February, 1984, to examine several critical health issues during the following five months. I ask that your institution participate in this important effort by appointing Mr. Gerry Hiebert.

The Review Committee will be comprised of approximately fifteen members from urban hospitals, rural hospitals, the College of Physicians and Surgeons, the University of Manitoba, the Manitoba Medical Association, the Manitoba Association of Registered Nurses, and senior government staff. The Review Committee is intended to function as a steering committee, striking sub-committees with expanded membership to review selected topics.

The terms of reference for the Review Committee are to examine current health issues and recommend future directions to the Minister of Health. Specific issues for review have not been defined for the Committee. The Committee will establish its own agenda. Examples of key topics include:

(a) hospital bed supply;
(b) ophthalmology services; and,
(c) alternatives to hospital admission.

... 2

This listing is not intended to be exhaustive.

It is intended that members of the Review Committee meet twice per month. I have requested the Manitoba Health Services Commission to reimburse committee members for travel costs and other out-of-pocket expenses. I trust that sponsoring agencies will provide sessional fees for Review Committee members where necessary.

The suggested afternoon meeting schedule in the M.H.S.C. executive boardroom is as follows:

February 20
March 5, 19
April 2, 16
May 7, 22
June 4, 18

The secretarial/support services will be provided by the Research and Planning Directorate. If you have any questions, please contact the Chairman of the Review Committee, David Pascoe, at 772-7702; 206 - 1580 Dublin Avenue, Winnipeg, R3E 0L4.

Please notify Mr. Pascoe of your decision to participate on the Review Committee. I wish to thank you in advance for your anticipated co-operation.

Yours sincerely,

ORIGINAL SIGNED BY
L. L. DESJARDINS

L. L. Desjardins

APPENDIX B

ADMINISTRATIVE IMPACTS SUB-COMMITTEE

Mr. J. Litvack, Chairman
Mr. N. Kalansky
Mr. D. Krack, Recording Secretary
Mr. G. Chapman
Mr. A. Hiebert
Mr. P. Pauls

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Dr. J. Barwinsky, Chairman
Dr. G. Collins
Dr. J. McDowell
Dr. T. Miller
Dr. D. Mymin
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Mrs. H. Shortridge
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Ms. M. McKenzie
Ms. E. Shapiro
Dr. L. Stephen
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Dr. J. Horne

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- Mr. E. Goerz
- Dr. J. Hurwitz, Chairman
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- Dr. J. Menzies
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- Ms. M. Rogers
- Ms. K. Thomson
- Mr. B. Woods

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- Dr. H. Greenberg
- Dr. R. Kippen
- Dr. K. McIver
- Dr. W. Myers
- Dr. L. Roos
- Dr. C. Saunders
- Dr. C. Wightman

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Ms. L. Drew
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Dr. R. Postuma
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Dr. R. Menzies
Dr. I. Morrison
Mrs. E. Parker
Dr. M. Seshia
Dr. H. Wiens

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Ms. B. Wong

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Ms. G. Coyston
Dr. I. Elliott
Ms. V. Holsteen
Dr. P. Mirwaldt
Dr. C. Murphy, Chairman
Ms. H. Payne, Recording Secretary
Ms. R. Tamblyn

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Dr. R. Postuma
Dr. F. Ross
Ms. R. Tamblyn

RESPIRATORY SUB-COMMITTEE

Dr. N. Anthonisen, Chairman
Mr. S. Drain, Recording Secretary
Ms. L. Fredette-Feakes
Dr. D. Johnson
Dr. J. Manfreda
Ms. J. Porth

TERMINALLY-ILL SUB-COMMITTEE

Mr. T. Bartman
Ms. A. Brown
Dr. P. Henteleff, Chairman
Dr. M. Levitt
Mrs. A. Nemecek, Recording Secretary
Ms. S. Sohar
Dr. C. Unruh

APPENDIX C

MANITOBA

MINISTER OF HEALTH
MINISTRE DE LA SANTÉ

WINNIPEG, MANITOBA
R3C 3R8

JUN 14 1984

Dear

Recently, I requested several organizations[1] to participate in a review of Manitoba's health services. Representatives have been selected for this Health Services Review Committee to consider immediate issues such as cost constraint and future issues such as structures for health service delivery. The Health Services Review Committee intends to use the services of several sub-committees to investigate particular topics which require analysis and review. I appreciate your interest to participate as a sub-committee chairman.

The deliberations of the sub-committees are to take into account:

a) the maintenance of efficacious health care;

b) the acceptance of prudent fiscal restraint; and,

c) the projected increased demand for health services brought about by the anticipated increase in the number of elderly.

---

[1] Manitoba Medical Association; Misericordia General Hospital; College of Physicians and Surgeons; Rural Hospital (Portage); Health Sciences Centre; Social and Preventive Medicine; University of Manitoba; St. Boniface General Hospital; Manitoba Association of Registered Nurses.

...2

Alternatives to be considered include a shift in focus from inpatient treatment to treatment on a day patient basis. This mode of treatment assumes an appropriate level of home health services to provide adequate support and/or alternative care in the patient's home. Also to be considered are current patterns of utilization of inpatient beds and the allocation of the required number of inpatient beds. Consideration will be given to the designation of certain specialty programs as provincial health care programs, with the appropriate allocation of resources to meet demonstrated patient needs. This overall review will include patient utilisation in both urban and rural areas.

Given this context, I suggest that each sub-committee undertake its review within its terms of reference while taking into account the province's fiscal constraints. While government may be able to consider alternative types of services, the previous pattern of extensive service expansion will not likely re-occur in the foreseeable future. Rather than impose unilateral resource allocation, we have chosen to consult with key experts in the industry.

To focus the activities of all sub-committees, I provide the following terms of reference that are consistent with the Health Services Review Committee's mandate:

1) Each sub-committee will be requested to identify current and new categories of disease/treatment for which there is no alternative to hospitalization. Anticipating trends for the next decade for such categories may be based upon local experience and literature.

2) Each sub-committee will be requested to identify current and future categories of disease/treatment for which there are alternatives to traditional hospitalization. Recommendations for means to achieve the goal of increased out-of-hospital diagnosis/treatment will be welcomed. For each proposed change, the sub-committee will be requested to estimate the impact upon the quality of health care available in the future.

3) Although time is short, I would hope that sub-committees will be in a position to report to the Health Services Review Committee by September 30, 1984.

While the Health Services Review Committee may have suggested the names of some members for your sub-committee, please feel free to suggest additional membership that you feel appropriate (e.g. rural,

...3

physician, nursing, and other allied specialist representation). To elicit the cooperation and coordination necessary to bring together the variety of health care professionals you will have in support of the work of your sub-committee, please send your list of proposed sub-committee members to David Pascoe, Chairman of the Health Services Review Committee, 308 - 294 Portage Avenue, Winnipeg, Manitoba, R3C 0B9. Mr. Pascoe will confirm the membership of the sub-committee with the Health Services Review Committee. At least one member of the Health Services Review Committee will participate on each sub-committee to provide continuity. Professional support services to sub-committees will be provided (e.g.-minutes and data collection) by staff members of the Manitoba Health Services Commission or the Department of Health.

To begin the process, I will convene a seminar on June 19, 1984, 9:00 a.m. - 12:00 p.m., for all sub-committee chairmen to consider economic, population, and service delivery variables. Each sub-committee will be provided with information to serve its needs. Enclosed is an agenda for this seminar.

I thank you for your interest in participating in this important review process. The task before us is challenging and I am certain that the benefits that will accrue to Manitobans and the health care industry will be most rewarding. I look forward to the results of the review process.

Yours sincerely,

ORIGINAL SIGNED BY
L. L. DESJARDINS
L. L. Desjardins

Enclosure

Volume

2

REPORT OF THE HEALTH SERVICES REVIEW COMMITTEE

VOLUME II:
SUB-COMMITTEES' KEY FINDINGS AND RECOMMENDATIONS

REPORT OF THE
HEALTH SERVICES REVIEW COMMITTEE

VOLUME II: SUB-COMMITTEES' KEY FINDINGS AND RECOMMENDATIONS

November, 1985

Manitoba

Health

Health Services Commission
Research and Planning

308 Somerset Place
294 Portage Avenue
Winnipeg, Manitoba CANADA
R3C 0B9

(204) 945-8599

November 15, 1985

The Honourable L. L. Desjardins
Minister of Health

Sir:

On behalf of the Committee members, I have the honour to submit the Report of the Health Services Review Committee.

Respectfully submitted,

David Pascoe
Chairman
Health Services Review Committee

ACKNOWLEDGEMENTS

The Report of the Health Services Review Committee represents thousands of hours of input from members of the fifteen sub-committees, recording secretaries and Manitoba Health Services Commission data processing staff.

The Committee joins to express its thanks to the sub-committees' recording secretaries who aided sub-committee work with formal minutes of all meetings and drafts of the sub-committee reports. The recording secretaries included the following staff:

Linda Bakken - Manitoba Health Services Commission
Sean Drain - Manitoba Health Services Commission
Donald Krack - Manitoba Health Services Commission
Phyllis MacDonald - Manitoba Health Services Commission
Ann Nemecek - Manitoba Health Services Commission
Heather Payne - Manitoba Health Services Commission
Norma Schwabe - Manitoba Health Services Commission
Linda Webster - Manitoba Health

A special thanks is extended to Lucienne Stadnyk who coordinated all Health Services Review Committee correspondence as well as revisions to the drafts of this Report.

HEALTH SERVICES REVIEW COMMITTEE MEMBERSHIP*

Lloyd C. Bartlett, M.D.	Manitoba Medical Association, Urban
Ted I. Bartman	Urban Non-Teaching Hospitals
Kenneth R. Brown, M.D.	College of Physicians and Surgeons of Manitoba
Frank J. DeCock	Manitoba Health Services Commission
William W. Devine	Rural Hospitals
Brian I. Gudmundson, Recording Secretary	Manitoba Health Services Commission and Manitoba Health
Gerry P. Hiebert**	Urban Teaching Hospitals
John M. Horne, Ph.D.	Faculty of Medicine
Nick K. Kalansky**	Urban Teaching Hospitals
Bryan W. Kirk, M.D.	Faculty of Medicine
Jack T. Litvack	Urban Teaching Hospitals
John H. McBeath, M.B.	Manitoba Health Services Commission
David W. Pascoe, Chairman	Manitoba Health Services Commission and Manitoba Health
Lawrence J. Stephen, M.D.	Manitoba Medical Association, Rural
Robyn M. Tamblyn**	Manitoba Association of Registered Nurses
John G. Wade, M.D.	Faculty of Medicine
Jack C. Wilt, M.D.**	Manitoba Health

HEALTH SERVICES REVIEW COMMITTEE FOOTNOTES

* Individual contributions do not necessarily reflect the position of the sponsoring agencies or institutions.

** Position change during the review process:

1) Gerry Hiebert resigned from the Health Sciences Centre, effective June 30, 1984, and was replaced by Nick Kalansky.

2) Nick Kalansky changed place of employment from the Health Sciences Centre to St. Boniface General Hospital, effective September 30, 1985.

3) Robyn Tamblyn changed place of employment from the Manitoba Association of Registered Nurses to St. Boniface General Hospital, effective November 7, 1984.

4) Dr. Jack Wilt retired from Manitoba Health effective September, 1985.

VOLUME II

HEALTH SERVICES REVIEW COMMITTEE

SUB-COMMITTEES' KEY ISSUES AND RECOMMENDATIONS

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PROLOGUE:

The Health Services Review Committee is aware that the Manitoba health care system is currently functioning under considerable stress. Health care facilities appear to be operating at close to capacity and there are continuing demands for services which have the potential to tax existing resources to the limit.

During many months of deliberation, the Health Services Review Committee has reviewed a considerable body of data including:

Health care utilization trends;
Population projections;
Health care funding;
Manitoba and Medicare report;
Adult Medical Patient Study; and,
Fifteen sub-committee reports.

While it was recognized that health care facilities fulfill a particular role and should be adequately resourced for that purpose, a common theme emerged to investigate viable alternatives to institutional care. All sub-committees eagerly responded to the challenge and made a genuine attempt to come to grips with the problems of increased demands upon existing fiscal and health care facility resources.

The present pressures on the system are exacerbated by a general reliance upon in-patient institutional resources. The development of the health system, since the advent of hospital insurance and Medicare, has emphasized acute care resources. Health care practitioners are often frustrated by their inability to implement viable alternatives to traditional modalities of care and cure. This reliance upon institutional resources manifests itself dramatically in the treatment and care of the elderly.

The Health Services Review Committee perceived that the province's ability to respond to health care delivery needs in Manitoba could be directed in one of several ways. These include:

1. More money for more of the same services; or,
2. Rationing of health care resources; or,
3. Develop innovative alternatives of treatment and prevention to the present emphasis on in-patient services.

The Health Services Review Committee concluded that the third option was the way to proceed. It merits support from all sections of the health care delivery system, including health providers (physicians, nurses, the Boards and administration), the public-at-large, and government. All sub-committees seriously addressed the issues and provided a number of recommendations and proposals in support of the third option, providing a cost effective continuum of accessible and appropriate health care services (ambulatory, institutional, and post-discharge supports).

The mandate from the Minister of Health to review Manitoba's health delivery network was to address innovative program ideas. All the work of the sub-committees and the Health Services Review Committee led them to concur that such emphasis is appropriate and timely for Manitoba. The recommendations from the sub-committees were considered seriously. All fifteen sub-committee chairmen are recognized leaders within their field. Thus, the review process was not an insulated, bureaucratic attempt at health care planning. Rather, it was an innovative exercise in consultation and deliberation.

To provide cost effective quality health care for Manitobans is a challenge for the entire health care system. It is proposed that the Minister continue to actively seek the assistance and counsel of the broadest constituency within the health care field in order to assure that the recommendations and proposals outlined in the Report can be translated into practical reality.

REVIEW PROCESS:

The Health Services Review Committee was formulated in December, 1983, with an invitation from the Minister of Health to individuals to participate in this ministerial review committee. This letter of invitation, which appears as Appendix A, established a framework within which Committee members were requested to participate.

The structure of the Committee was based on representation from a variety of health care segments. These included fifteen representatives from:

The College of Physicians and Surgeons of Manitoba;
Manitoba Association of Registered Nurses;
Manitoba Health;
Manitoba Health Services Commission;
Manitoba Medical Association, (Rural and Urban);
Rural Hospitals;
Faculty of Medicine, (University of Manitoba);
Urban Non-Teaching Hospitals; and,
Urban Teaching Hospitals.

This broad constituency provided a balance between institutional and organizational forces and crossed the boundaries of educational, funding, and service concerns.

The first meeting of the Health Services Review Committee was convened in February, 1984, at which time the Committee defined its work according to four broad topics. These topics were:

1) Areas which required further investigation;
2) The possible establishment of sub-committees to undertake studies on behalf of the Health Services Review Committee;
3) The process by which sub-committee reports would be received; and,
4) The form in which the Committee's work would be presented to the Minister of Health.

At subsequent meetings, the Health Services Review Committee refined its task to include four objectives. Thus, the terms of reference for the Health Services Review Committee were adopted by the Committee members and are listed as follows:

To identify major cost areas and explore consolidation;
To look for alternatives to in-patient services (e.g. - more ambulatory care);
To review current bed allocation and utilization; and,
To review criteria of hospital admissions in both urban and rural hospitals.

The Committee chose, as its vehicle of investigation, the formulation of sub-committees which were tasked to undertake specific investigations on behalf of the Health Services Review Committee. Areas of investigation were selected according to pressing issues of the day combined with those areas which presently consume a large majority of hospital days and medical services. The area of mental illness was not included under the review of the Health Services Review Committee as this had previously been reviewed with a report being tabled with the Minister of Health entitled "Mental Health Services In Manitoba, A Review and Recommendations" September, 1983.

The Health Services Review Committee thus commissioned fifteen sub-committees which reviewed the following areas:

Administrative Impacts;
Cardiovascular;
Community Health;
Critical Care;
Elderly;
Emergency;
Gastrointestinal;
Indian Health Services;
Not-For-Admission Surgery;
Obstetrics;
Oncology;
Out-Patient Medical Services;
Pediatrics;
Respiratory; and,
Terminal Illness.

During the working time of the Committee, one other review had been commissioned by the Manitoba Health Services Commission. This was a review of ophthalmology services. Although this report was not commissioned by the Health Services Review Committee, it was reviewed within the context of the overall scope of the Committee's activities.

The work of the sub-committees began with the appointment of chairmen. Chairmen were requested to prepare a membership list which required ratification by the Health Services Review Committee. In broad terms, the sub-committee's membership was constituted to balance medical input from both rural and urban practitioners, input from nursing representatives and such allied health specialists as were appropriate to the work of individual committees. Support was provided to the sub-committees by representatives of the Manitoba Health Services Commission and Manitoba Health (formerly referred to as the Department of Health). These staff members were responsible for scheduling meetings, preparing minutes, and facilitating special data runs of Manitoba Health Services Commission hospital and medical statistics. In order to provide a linkage between the Health Services Review Committee and the sub-committees, at least one member of the Health Services Review Committee was appointed as a liaison with the fifteen commissioned sub-committees. All sub-committees were supported by unique data runs of the Manitoba Health Services Commission hospital and medical statistics. Membership of the fifteen sub-committees is attached as Appendix B.

In order to provide each sub-committee chairman with an introduction to the context of the review process, a meeting was convened with the Minister of Health at which time information was presented to sub-committee chairmen. This meeting was held in June, 1984, and the letter of introduction from the Minister of Health to sub-committee chairmen is attached as Appendix C.

During the time that the Health Services Review Committee had commissioned the fifteen sub-committee reports and the tabling of these reports with the Committee, work was done to review existing information prepared by the Manitoba Health Services Commission and relevant studies which were undertaken or were currently underway at the time of the review process. The economic situation of the Province of Manitoba was presented for review by Committee members, as was general information regarding the organization of health care services in Manitoba and the trends of health service utilization and cost escalation experienced during the previous decade.

During the 1980's, the economic situation in Manitoba was less volatile than other Western Canadian provinces due to Manitoba's diversified economic base. This diversification provided Manitoba with greater resistance against the forces of recession. In 1982, Canada experienced a negative growth rate of 4.6% of the gross national product, while Manitoba experienced a negative growth rate of 2.9% of the gross domestic product. During this time unemployment in Manitoba stabilized somewhat and at the beginning of the work of the Health Services Review Committee Manitoba registered an unemployment rate of 9.4% compared to the Canadian average of 12.3%. When the Committee began its activities in February, 1984, the consumer price index for Winnipeg registered a 4.8% increase during the previous 12 months while the experience across the country was 5.5%. From June, 1981 to November, 1982, there was a net increase of 2,000 jobs registered within Manitoba. Although Manitoba fared relatively well during the period of the recession in the early 1980's, the debt of the Province of Manitoba continued to rise. The 1982 debt load for Manitoba on a per capita basis was the third highest in the country next to New Brunswick and Newfoundland. In 1982/83, 5% of the provincial budget was used to service the debt load while in 1983/84, that figure had risen to 9%.

This background information, provided for the benefit of the Health Services Review Committee, was interfaced with a Statistics Canada population study for the upcoming decade which projects a modest increase in the number of total residents in Manitoba. It is expected that between 1984 and 1995, Manitoba can expect a population increase of approximately 100,000 persons. Within this global increase, however, are three factors which were of interest to the Health Services Review Committee. The first factor included a rise in the proportion of individuals who are 65 years of age or older. By 1995 it is estimated that the elderly population will rise to 14% from 12% currently. The second factor of population change indicated a decrease of younger individuals, aged 0-14, from 22.6% to 19.8% by 1995. The third factor of population change was an anticipated decrease in the proportion of women of child bearing age as well as a slight decrease in the fertility rate.

In order to provide the members of the Health Services Review Committee with a historical review of health care utilization and expenditures, information was presented with regard to the budget of the Manitoba Health Services Commission from 1971 to 1981/82. Attention was focused on the budget of the Manitoba Health Services Commission and not on Manitoba Health because of the difficulty of attributing departmental expenditures according to programmatic commitments. The budget of the Manitoba Health Services Commission over this period of time rose at an average rate of 12.98% per year for ten years. After adjusting for inflationary trends, the budget of the Manitoba Health Services Commission grew at a real rate of 3% per year for a period of ten years. Thus, health care expenditures in Manitoba were relatively well buffered against the general trends of the recession.

SUB-COMMITTEE ON ADMINISTRATIVE IMPACTS

One of the major challenges confronting the health system is its overall organization and structure of management. The need is paramount for all components of the health care system to initiate, develop and maintain communicative and cooperative linkages to assure that a more effective network of services can become a reality.

Of the fifteen sub-committees, this one found itself dependent upon recommendations and approvals arising from the other fourteen sub-committees. The Sub-Committee on Administrative Impacts asked itself questions of efficiencies to what end. Like the Health Services Review Committee a focus of efficiencies required direction with one of the three options (as described in the Prologue):

1. More money for more of the same services; or,
2. Rationing of health care resources; or,
3. Develop innovative alternatives of treatment and prevention to the present emphasis on in-patient services.

Health Services Review Committee Comments

The Health Services Review Committee felt that existing structures for dialogue, information sharing and coordination of health care services were inadequate. The Committee is therefore requesting the sub-committee on administrative impacts to direct its attention to these issues and recommend viable alternatives. Their deliberations should bear in mind improved linkage between institutions, providers, community services, funding agencies and government within the context of the Health Services Review Committee's recommendations and report.

It was near the end of the review process that the Health Services Review Committee clarified its collective opinion that the third option was the way to proceed. Thus, the task of the sub-committee on administrative impacts was defined clearly but not early in the process. The Health Services Review Committee concurred that the work of this sub-committee should now begin and continue on a regular basis for advice to the Minister of Health. No recommendations were made by this sub-committee at the time of printing of the Report.

In reviewing its role within the overall context of the Health Services Review Committee, it was felt that the sub-committee could be most useful in achieving the following objectives:

- Assessing and vetting the administrative impacts of the approved recommendations of the other sub-committee reports.

- Acting as an assisting resource in explaining or clarifying the impacts of the Health Services Review Committee Report to the health care administration community of Manitoba.

The role of the sub-committee is therefore continuing and a subsidiary report will be presented to the Health Services Review Committee in the near future.

SUB-COMMITTEE ON CARDIOVASCULAR DISORDERS

The report of the sub-committee examining cardiovascular disorders reviewed current and future supply and demand for cardiovascular services. Generally, the report documented that existing facilities and manpower are adequate to satisfy current demand for services. The report projected that a slight increase in demand would occur during the next decade due to an increase in the number of elderly residents in Manitoba. The report noted that 35,600 patient days were utilized for ischemic heart disease within the total of 91,500 patient days for all cardiovascular disorders in 1983/84. The sub-committee anticipated a slight decrease in demand for pediatric cardiac surgery during the next decade. However, it was anticipated that the demand for adult invasive procedures for cardiovascular investigations would increase by approximately 10% during the next decade. The sub-committee observed that the rural bed supply, both adult and pediatric, was adequate for cardiovascular disorders. It was suggested that improved information would be required to document rural referral patterns to tertiary centres so that rural demands on urban beds could be predicted more accurately. The sub-committee also observed that cardiac diagnostic procedures (ultrasound and nuclear imaging) should be maintained as currently provided.

The recommendations of the sub-committee suggested expansion of ambulatory diagnostic facilities and N.F.A. surgical facilities to offset the anticipated increased demand. The sub-committee urged expansion of ambulatory facilities for diagnostic testing which could accommodate approximately 500 patients per year (35% of total patients). The sub-committee further recommended expansion of N.F.A. surgery and preadmission clinics to reduce demand on acute beds. It was urged that stress testing be provided outside hospitals. It was also suggested that education measures be undertaken to advise the public of conditions leading towards atherosclerotic heart disease. The sub-committee urged that pediatric cardiology specialists provide consultation in rural regions to assist with proper referrals to Winnipeg acute beds. The sub-committee anticipated that the demand for pacemakers (350 per year) will increase by approximately 20% (up to 420 per year) during the next decade but such services could be accommodated with the N.F.A. surgery expansion.

The sub-committee also urged utilization of trained nurse clinicians at St. Boniface General Hospital, Health Sciences Centre, and the Children's Centre. The proposed eleven nurse clinicians at these facilities could perform a necessary support function for existing acute beds. This recommendation would require approximately $450,000 of operating funding for nurse clinician staffing. Such funding may be possible through hospitals' trade offs within existing global budgets.

Health Services Review Committee Comments

The Health Services Review Committee concurred with the theme of recommendations to expand ambulatory facilities and services as an adequate measure to satisfy increased service demand. Regarding the nurse clinician funding, it was agreed that trade offs within hospitals' global funding was preferred over expanded funding to hospitals.

SUB-COMMITTEE ON CONTINUING CARE

The sub-committee reporting on the Continuing Care Program provided information with regard to the historical development of the program which began with its introduction in September, 1974. It provided information with regard to the comprehensiveness, the centralized coordination and policy direction, the multidisciplinary approach, and many other facets which culminate in this program being considered preeminent in its field throughout the country. The sub-committee focused on the fundamental guiding principle of the cooperation between hospital and community care providers. The sub-committee on continuing care emphasized the importance of enhanced information exchange and working relations between institutions and community health service workers if a greater proportion of health needs are to be provided by Community Services. In addition, the sub-committee submitted 27 recommendations on policy and operational issues that could enhance the efficiency and effectiveness of continuing care services.

Because of the particular size and complexity of the Winnipeg region, the sub-committee identified that approximately 90% of the issues appeared to be specific to Winnipeg and not other jurisdictions that are served by the province-wide Continuing Care Program. The Continuing Care Program is seen as a vehicle by which hospitalization and prolonged hospital stay can be reduced. The sub-committee's priority recommendation dealt with the interface between the hospitals and the Continuing Care Program.

The first recommendation concerned the establishment of a conjoint planning committee which would be a standing committee made up of representatives from hospitals, the Continuing Care Program, the Manitoba Health Services Commission, Manitoba Health, and the community-at-large. The focus of this committee would be on three major areas which include:

a) to achieve integrated planning of services in the community and institutional sectors;
b) to review and assess proposals for developing services; and,
c) to monitor and review programs.

The sub-committee presented a variety of administrative matters such as the introduction of new treatment modalities, the introduction of demonstration projects, and the like. The sub-committee also discussed the need for convalescent beds and long-term hospital beds for the care of persons requiring very heavy or specialized care.

The final area included in the report on the Continuing Care Program concerned the present structure of funding which includes a variety of services provided by the Victorian Order of Nurses within the City of Winnipeg, and a combination of province-sponsored services in rural Manitoba, and in Winnipeg for long-term care clients. This structure of establishing an annual operating budget for the program provides efficient flexibility for program sponsors to respond to the variable demands placed on the program. Such a mechanism is not available to provide continuing care services as regards those aspects sponsored by government. The current system to provide services to long-term clients of the Continuing Care Program residing in Winnipeg and the provision of services to rural Manitobans does not have sufficient flexibility to respond either to the needs of those on the Home Care Program or to the demands of the health care facilities to support early discharge. The reason for this lack of flexibility rests in the financial structure established by government which sets staff year quotas and which is subjected to the intermittent restraint policies of government which culminate in staffing freezes and ultimately shrink the resource base of the program.

The health service network in Manitoba is seen to be an integration between institutional, medical, and community services, all of which form an integral part for the efficient and effective delivery of health services. When one component is arbitrarily impeded, for example by staffing restrictions, the pressure is then transferred to the other components of service. This creates a situation of imbalance, unnecessary pressures, and ultimately results in individuals being admitted to hospital and remaining there for an excessive length of time.

Health Services Review Committee Comments

The Health Services Review Committee supported the establishment of a conjoint planning committee as defined. It also supported the continuation of the funding principles of the Continuing Care Program which include the need to change the service base of the program in accordance with population changes and the establishment and maintenance of cost limits by case mix.

The Health Services Review Committee also supported the need for convalescent beds and long-term hospital beds for the care of persons requiring very heavy or specialized care. This emphasis was consistent with the sub-committee report of Health Care for the Elderly. Both sub-committee reports defined short-term needs for extended treatment beds and respite beds. This finding was supported by the Health Services Review Committee.

The Health Services Review Committee concluded that an operating grant (i.e., global budget) be established each year for the Continuing Care Program. Such services were defined as fundamental support to the entire health care system. It is necessary that the Continuing Care Program have the flexibility to meet a variable demand for service. If not, other service areas (i.e., hospitals) may become overstressed.

SUB-COMMITTEE ON CRITICAL CARE

The focus of the Sub-Committee on Critical Care was to define factors contributing to high stress upon medical care services and project contributing factors which will likely increase demands for critical care in the future. The sub-committee defined critical care as an arbitrary line drawn at an upper end of the continuum of patient care which defines many resources concentrated for the purpose of improving the survival of the most seriously ill. By contrast, critical care patients may receive 30 hours nursing care per day as compared to 5 hours nursing care per day for standard ward care. Currently, no intermediary level of care is available for practitioners to transfer patients.

The sub-committee on critical care defined Northern Manitoba hospital beds as adequate. However, the sub-committee report noted a continuing staffing problem in the North. Both bed supply and manpower availability for rural hospitals were defined as adequate by the sub-committee. Critical care units within urban community hospitals were defined as being under great pressure. The sub-committee noted a perceived bed shortage resulting from blocked medical beds. It was felt that the unavailability of medical beds impedes transfer of patients from critical care units when appropriate. The sub-committee also noted that the Winnipeg tertiary hospitals (Health Sciences Centre, St. Boniface General Hospital, and Children's Centre) have observed increasing patient acuity and complexity of patients' requirements. The urban tertiary hospitals have experienced both problems of staff recruitment and retention for medical and nursing staff which has led to occupancy of only 50-60% in the critical care units. Also, the sub-committee described the existing transportation system as inadequate.

Over the next decade, the sub-committee projected that a slow increase in the demand for critical care beds would result from the following factors:

1. Heightened public expectations;
2. Improved transportation from rural and remote areas;
3. More cardiac surgery;

4. Upgrading of the neurosurgery program; and,
5. Increased numbers of patients suffering from complications of cancer chemotherapy and transplantation.

The implications of such projections were identified by the sub-committee as follows:

1. A slow increase in demand in urban community hospitals and tertiary hospitals would result in increased acuity of patients.
2. A continued shortage of trained intensive care nurses in Manitoba would continue the present pressures upon critical care units.
3. The shortage of physicians in Northern Manitoba and tertiary hospitals is likely to persist.

To correct these problems, the sub-committee provided four recommendations as follows:

1. Existing physician shortages should be eliminated with increased training of intensive care nurses.
2. Intermediary care beds should be developed (from the existing bed supply) to serve as step-down beds between the critical care units and standard ward care.
3. Professional associations should develop standard qualifications for both medical and nursing personnel to serve in critical care units.
4. The Report of the College of Physicians and Surgeons of Manitoba on transportation and northern medical services should be implemented by the Manitoba Health Services Commission.

Health Services Review Committee Comments

The Health Services Review Committee concurred with the emphasis of the critical care sub-committee report. It was felt that critical care units should have the capacity to respond to appropriate demands for patient care. It was noted, however, that no standard criteria exists for defining the "appropriate" admission criteria for critical care units among tertiary hospitals and community hospitals. The Health

Services Review Committee emphasized the interaction and dependency between the components of the health care system. The recommendations of the critical care sub-committee were to be reviewed within the context of the report of the Health Services Review Committee to provide alternative services and reduce demand on existing hospitals. The future monitoring of appropriate admissions by the hospital's admission and discharge committees could serve to regulate inappropriate demand upon critical care units. This monitoring function could also serve to facilitate transfer of patients from critical care units to either step-down intermediate beds or standard ward care where appropriate.

SUB-COMMITTEE ON HEALTH SERVICES FOR THE ELDERLY

The prevalent theme of the report of the sub-committee on health services to the elderly was to provide "supported independence" to keep the elderly out of institutional settings by providing adequate supports in the community. This concept of "supported independence" was emphasized even if it requires calculated risk-taking by the patient, family, and health practitioners. The sub-committee urged an expanded array of ambulatory services and institutional services to appropriately respond to the needs of the elderly.

The sub-committee urged that the rate of elderly institutional utilization must be closely monitored. The connotation of the elderly patient as the major or sole "bed blocker" in acute hospitals was refuted strongly by the sub-committee. It was noted that in-patients awaiting transfer span all ages and diagnostic groups as mentioned in other sub-committee reports (i.e., Continuing Care Sub-committee). It was recommended that geriatric assessment and consultation be utilized to guide subsequent management of treatment and reduce inappropriate use of institutional services.

It was suggested that the use of personal care homes as a "point of no return" should be changed. The sub-committee urged change to the panel process for personal care home admission and discharge. The sub-committee noted that the panel process functions in a gatekeeper role to the use of the most expensive resource, namely the personal care homes. Such institutionalization may also result in the loss of personal freedom for the patient. The panel process serves a pivotal role in the system for effective, efficient, and appropriate care. It was urged that a geriatrician be included in the panel membership. It was felt that panel members should not have a competing interest in the panel disposition (e.g. - pressures on continuing care may influence decision to admit to a personal care home).

The sub-committee indicated that the demand for personal care home beds can be reduced by targeting new resources at supported independence and supporting caring families. Discharge options were stressed by the sub-committee to include the following:

a) expanded respite care, including publicizing such services;
b) expanded home care staffing to relieve critical staff shortages;
c) maintenance of existing adult day care services based in hospitals;
d) consideration of housing options to satisfy support needs for the frailer tenants; and,
e) provision of senior centres in areas of high density elderly populations to provide for socializing activities.

The sub-committee documented the existing fragmentation of services and urged improved organizational control through a single departmental structure. The sub-committee felt that the topic of coordination of the array of services for the elderly and the problem of in-patient inefficiencies should be studied further by an ongoing committee.

Health Services Review Committee Comments

The Health Services Review Committee concurred with the sub-committee's theme to provide "supported independence" for the elderly. The separate recommendations from the sub-committee report received broad acceptance from the Health Services Review Committee. Specifically, the establishment of improved admission and discharge criteria for personal care homes was felt essential. Expansion of a variety of support services for the elderly was endorsed as appropriate and less costly. A consequence of such measures would allow for reduced demand on existing acute hospital beds.

SUB-COMMITTEE ON EMERGENCY HEALTH CARE

The emergency health care sub-committee documented several major problems regularly confronting staff in hospitals' emergency departments. The sub-committee argued that hospitals' emergency departments are under great pressure at all times from the public, physicians, and other hospital departments. The sub-committee concluded that the major reason for such pressures stems back to the hospitals' admission and discharge policies. Another reason noted by the sub-committee was the hospitals' organizational problem including training level uniformity and the need for greater coordination among hospital departments and among different hospitals.

The sub-committee perceived that many patients who are admitted from emergency departments stay an unacceptably long time in the emergency department because of bed shortages. Emergency departments are thus faced with requirements of new patients seeking services of emergency departments without the ability to transfer other stabilized patients to appropriate hospital wards. It was recommended that each hospital should have an active bed utilization committee responsible for admission and discharge planning. The sub-committee noted that some elderly patients who had been panelled for personal care home placement remained for an unacceptably long time in acute beds. To serve this problem, the sub-committee recommended that alternative placement of these chronic care patients be a priority for discharge. The function of appropriate discharge was underscored by the sub-committee so that patient overcrowding in acute hospitals would not spill over into emergency departments.

The sub-committee stressed the need to expand emergency services in remote/rural communities. Also, such remote/rural services were recommended to meet uniform standards. Addressing existing organizational problems, the sub-committee urged that a medical director of provincial emergency services be appointed to establish guidelines for the level of training of physicians, nurses and prehospital care personnel. The sub-committee specified training levels for such personnel to respond appropriately to current patient requirements. The sub-committee also indicated health promotion areas to minimize the demands upon acute hospital services including the following:

a) reduction of the number of exemptions from seat belt and helmet legislation;
b) increase support for advertising to discourage drinking and driving; and,
c) providing training to the public to administer cardiopulmonary resuscitation (CPR).

Health Services Review Committee Comments:

The Health Services Review Committee concurred with the recommendations that admission and discharge criteria for both acute hospitals and personal care homes should be reviewed promptly. It was seen that provision of appropriate discharge from acute hospitals would relieve some burden from the emergency department. The recommendation to increase discharge by expanding alternate forms of community health care programs was consistent with several other sub-committee reports. The questions of operational efficiencies raised by the sub-committee's report were referred to the sub-committee examining administrative efficiencies.

SUB-COMMITTEE ON GASTROINTESTINAL DISORDERS

The focus of the sub-committee on gastrointestinal disorders was on expansion of diagnostic procedures for early detection and treatment. The sub-committee recommended:

a) expansion of Computed Tomography (C.T.) scanning and ultrasound capabilities;
b) expanded use of stool, occult, blood testing;
c) greater use of double contrast gastrointestinal (G-I), radiological examinations;
d) use of flexible colonoscopy in regional centres; and,
e) consideration of nuclear magnetic resonance (NMR) scanning.

In addition to expanded diagnostic services, the sub-committee recommended expansion of facilities for N.F.A. surgery.

The sub-committee suggested that "mini regions" be developed to allow concentration of diagnostic and therapeutic equipment while preventing costly duplication of inadequate facilities.

Health Services Review Committee Comments

The Health Services Review Committee concurred with the sub-committee's themes of expanded ambulatory diagnostic procedures and expanded N.F.A. surgery capabilities. However, the Health Services Review Committee cautioned that criteria be adopted to define appropriate use of diagnostic tests. Unnecessary or excessive diagnostic testing should be avoided to prevent an artifical demand of services upon the health care industry. The Health Services Review Committee concurred that C.T. scanning capabilities in Manitoba require expansion based upon a formula for procedures per population. Location within the province for expanded C.T. scanning capability was not prescribed by the sub-committee or by the Health Services Review Committee.

The Health Services Review Committee concluded that facilities for ultrasound testing throughout the province are adequate, however, a problem of retention of qualified staff for ultrasound testing does exist in some rural centres. It was felt that this staffing problem required resolution.

The sub-committee's recommendations for expanded ambulatory diagnostic testing and expanded N.F.A. surgery capacity were consistent with several other sub-committee's recommendations.

SUB-COMMITTEE ON INDIAN HEALTH CARE

The sub-committee on Indian Health Care undertook an extensive review of health conditions of Manitoba's Indian and the Inuit of the Keewatin area of the Northwest Territories. The sub-committee also considered the health care circumstances of Metis and Non-Status Indians. The report documents that the incidence of morbidity is substantially higher for Indians than the general population. The plethora of organizational structures adds to the complexity of improving the health status of the Native population. The sub-committee observed that the topic has been studied repeatedly with few significant changes for Native health issues. The jurisdictional disputes among governments and among departments overshadow the health care delivery system.

In epidemiology of Natives, both chronic and lifestyle diseases dominate the epidemiology for Natives. The incidence of otitis media and meningitis amongst Native children would be considered unacceptable in other populations. Indian and Inuit children are now virtually the only source of new rheumatic fever seen in Manitoba's hospitals. Diabetes is now considered to be an epidemic in the adult Indian population. Chronic disorders amongst Natives are also increasing. Overcrowded housing, poor water and sanitation, and high unemployment contribute to the ill health of Indian people. The impact of these social and environmental indices on health is evident in suicide rates and psychiatric illness that far exceed national averages. The sub-committee report defined the high health service utilization of Natives as a consequence of the social and environmental factors. The sub-committee report emphasized that improvement of health conditions for Natives could not be achieved without addressing the jurisdictional ambiguities and disputes between departments and between provincial and federal governments.

A common theme of the sub-committee's discussions was that Indians must be involved in, and have control of, health care delivery in Indian communities. The committee stressed that the Native population be involved in health care planning and service delivery to help set priorities, to recruit staff, and to design appropriate training methods.

The sub-committee urged recognition of the provincial government's role as a partner in the provision of health services to Indians. It was noted that the special relationship which has existed between Indians and the federal government would not be diminished by an altered relationship with the provincial government. The sub-committee recognized the validity of the Indians' request for local control to participate as full partners in the planning, implementation, and evaluation of health programs. To achieve this end, a mechanism of a tripartite arrangement of equal participants was emphasized by the sub-committee. The tripartite mechanism could function to make decisions at the most senior level regarding the federal government, the provincial government and the Indian community.

Health Services Review Committee Comments

The Health Services Review Committee endorsed the recommendations of the sub-committee on Indian health care. It was recognized that additional data would be required in addition to decisions to define age appropriate and geographic appropriate means to improve health care delivery for the Native population. The tripartite mechanism would serve as the appropriate vehicle to this end.

SUB-COMMITTEE ON NOT-FOR-ADMISSION (N.F.A.) SURGERY

The sub-committee reviewed the present experience of N.F.A. surgery in Manitoba and considered the possibility of transferring appropriate in-patient cases to this method of surgery. The sub-committee reviewed Manitoba data and experience in United States' centres and concluded that there were indeed numerous possibilities to expand N.F.A. surgery on cases that are currently treated on an in-patient basis. In order to support this transfer, the systematic development of N.F.A. surgical programs was recommended with the proviso that concurrent with this was the development and implementation of:

1) preadmission evaluation, instruction and preparation of the patient;
2) preoperative anesthesia assessment;
3) a postoperative recovery room and observation area with dedicated staff; and,
4) provision for postoperative follow-up including home nursing visits.

This change in emphasis from in-patient to N.F.A. surgery was seen to have substantial benefits to the physicians, the hospitals, and to the provincial government. It is also seen to be highly supported by the public, both as it applies to cost savings and the convenience of this service being done on a same day basis.

Health Services Review Committee Comments

This systematic development of N.F.A. surgery services is supported by the Health Services Review Committee. As a means to provide appropriate and accessible care, expanded N.F.A. surgical services could also reduce existing demands upon acute beds.

SUB-COMMITTEE ON OBSTETRICS

This sub-committee provided a variety of recommendations grouped around seven areas. These were:

- antepartum care;
- postpartum care;
- neonatology;

- gynecology
- bed distribution in Winnipeg and outside areas;
- the role of the nurse in reproductive health care; and
- professional education.

Running through these recommendations were a variety of topics which were the focus of the work of the sub-committee.

The obstetric sub-committee endorsed the concept of making maximum use of in-patient beds by way of a commitment to expand ambulatory services. In order to facilitate this change in focus, the sub-committee recommended a city-wide expansion of pilot projects like those established at the St. Boniface General Hospital. These projects include a postpartum early discharge program and an antepartum nurse visiting service. On the basis of pilot projects, the data suggests that the average length of stay of post-partum obstetrical patients could be reduced quite significantly. The requirement of in-patient beds for the management of antepartum cases could also be reduced by a home visiting service.

The history of obstetrical care in Winnipeg indicates that an increasing number of deliveries are being accommodated at the two teaching hospitals. The sub-committee recommended expansion of perinatal units at Health Sciences Centre and St. Boniface General Hospital to allow 4,500 deliveries per centre per year. If this can be accommodated, the need for additional obstetrical units should be reviewed with the thought that savings could accrue from consolidation of services. The sub-committee recommended that a process of gradual consolidation be adopted. This would see the consolidation of obstetrical services, first into four units, and then, after monitoring the results of the recommended community programs and ambulatory care services, consideration might be given to consolidation of obstetrical services into three facilities.

Finally, the sub-committee turned its attention to the expanded role of the nurse in reproductive health care and the need for continuing professional and patient education. With regard to the former, the sub-committee recommended consideration of a training course for neonatal nurse clinicians recognizing the difficulty in retaining neonatologists.

Health Services Review Committee Comments

The Health Services Review Committee was very supportive of expanded not-for-admission and out-patient services. As rural Manitoba residents use the teaching hospitals' obstetrical units for a variety of services, the introduction of a hostel to support ambulatory care patients and the discharge of postpartum patients is recommended. The sub-committee put forth criteria with regard to the average length of stay which in combination with the proposed expanded early discharge program and antepartum nurse visiting service, would increase the likelihood of eventual consolidation of obstetrical services into three centres in Winnipeg. The Health Services Review Committee acknowledged the difficulty in retaining neonatologists and recommends consideration of the proposal to train neonatal nurse clinicians by the educational institutions and funding bodies.

SUB-COMMITTEE ON ONCOLOGY

The sub-committee report on oncology reviewed incidence of morbidity, new technological developments, and specified a functional outline for a provincial oncology program. The reported incidence of oncology cases has increased at an annual rate of 3.5% during the last two decades in Manitoba. The sub-committee report anticipated future technological breakthroughs to prevent and cure cancer.

The sub-committee report urged expansion of prevention activities such as workplace safety monitoring, anti-smoking advertising, and continued screening for breast cancer. Regarding changes to treatment modalities, the sub-committee recommended that ambulatory services be expanded and that 40 acute beds be dedicated for oncology use.

It was suggested that N.F.A. surgery facilities at the Health Sciences Centre should be upgraded. At a limited cost to provide additional recovery space, two N.F.A. operating theatres could be created. As a consequence, a surgical bed reduction at the Health Sciences Centre could follow with decreased demand for surgical beds. It was noted that private practitioners would refer patients for N.F.A. surgery. It was not intended to change the relationship between the private practitioner and the patient.

The sub-committee report urged an increase in radiotherapy staffing from 7.0 staff to 9.0 staff. In addition, the sub-committee report recommended that 20 dedicated beds be established for medical oncology as well as 20 dedicated beds for surgical oncology/radiotherapy. It was argued that the dedicated beds may reduce patient complications and reduce the average length of stay.

For pediatric oncology, the sub-committee noted that long-term survival rates had increased from 15% to 65% during the last two decades. Most pediatric oncology patients are treated on an ambulatory basis. Others face prolonged hospitalization due to complex therapeutic regimes. The need for resources for care in the home for terminal pediatric cases was defined clearly.

The hostel bed supply in Winnipeg for rural patients was reported for pediatric and adult clientele. It was noted that pediatric patients' needs are met adequately at the Ronald MacDonald House. However, it was suggested that the user fee of $30 per day at the Lennox Bell Hostel served as a deterrent for several adult oncology patients.

It was suggested that a central registry for oncology patients should be established. The purpose of the central registry is to suggest preferred modes of treatment based on diagnosis. This recommendation specified that the central registry could be maintained by the Manitoba Cancer and Research Foundation with cooperation from private practitioners.

Health Services Review Committee Comments

The sub-committee report supports the theme of cancer prevention. Expanded ambulatory care and N.F.A. surgery expansion were endorsed by the Health Services Review Committee. The consequences of such changes would be appropriate quality patient care as well as reduced demand on acute hospital beds.

The Health Services Review Committee agreed that effective in-patient services would require close patient supervision and patient isolation from infection. The issue of dedicated beds for this purpose at the Health Sciences Centre was defined as a jurisdictional dispute. Negotiation of organizational boundaries was to be left open to the service providers.

SUB-COMMITTEE ON OUT-PATIENTS

Restructuring and expansion of out-patient facilities were the fundamental principles of the out-patients sub-committee report. The report documented the literature which supports expansion of ambulatory services as a means of controlling the increasing costs of health care. The sub-committee proposed improved utilization by reducing hospital admissions and reducing lengths of stay through three basic mechanisms:

a) expansion of diagnostic and therapeutic services which currently require admission to hospital (dialysis programs, chemotherapy programs, out-patient intervenous antibiotics programs, ambulatory Total Parenteral Nutrition programs, and high-risk prenatal care programs);

b) expanded ambulatory services (diagnostic therapeutic and support services) for the elderly as a target population would reduce the frequency of acute exacerbations and complications and thus avoid the need for in-patient admissions; and,

c) the average length of stay for in-patients could also be reduced with greater availability of ambulatory services such as:

1. preoperative evaluation and treatment of patients requiring surgery;
2. postoperative care and supervision allowing earlier discharge from hospital following surgery;
3. on-going provision of medical treatment initiated in hospital allowing earlier discharge of medical patients; and,
4. out-patient rehabilitation programs.

The sub-committee's report limited its attention to two types of out-patient care including hospital based out-patient clinics and community-based primary care clinics. The topics of emergency departments, N.F.A. surgery, and physicians' services in private offices were not included within the scope of this sub-committee's activities.

The sub-committee recommended a significant administrative restructuring for hospital out-patient departments. The sub-committee urged that out-patient departments should be established as a separate administrative division within the parent hospital. This change would imply that each out-patient department would function as a separate cost centre and be held accountable for its budget. Within teaching hospitals, the sub-committee recommended that educational costs be identified as a separate item from provision of direct service. The sub-committee emphasized that the previous funding ambiguity between Manitoba Health and Manitoba Education regarding responsibility for educational costs should be resolved through funding from a single source for both purposes. Additionally, the sub-committee recognized that new cost-sharing arrangements for out-patient services in teaching hospitals would be required. They concluded that geographical full-time physicians (G.F.T.'s) should return a portion of the fee-generated-income to out-patient departments to offset their operating costs. To begin such program expansion, the sub-committee recommended that four model ambulatory services be established as models to serve as teaching locals. The four models included both tertiary hospitals' out-patient departments in Winnipeg, one community hospital out-patient department, and one community-orientated primary care program. The intent to create such model ambulatory care facilities was as follows: a) to develop and implement new types of out-patient services; b) to provide teaching and experience for undergraduate and graduate medical trainees, nurses, allied health care professionals, and hospital administrators; and, c) to evaluate the impact of expanded out-patient services on both the quality and cost of health care. Following such evaluations, the sub-committee urged that other out-patient services throughout Manitoba be expanded at a later date.

Health Services Review Committee Comments

The Health Services Review Committee endorsed these major themes of the out-patient sub-committee report. Implementation of such recommendations would clearly reduce the need to build more acute beds in Manitoba. Future bed utilization review was seen by the Health Services Review Committee as essential to avoid "freed up beds" from being filled by chronic long-term patients. The interrelated components of the health system should be monitored so as not to burden or overstress any particular area.

The Health Services Review Committee noted that the recommendations of the out-patient sub-committee report were consistent with many of the other sub-committee reports. The Health Services Review Committee acknowledged that the existing funding ambiguity for teaching hospital out-patient departments must be clarified promptly.

SUB-COMMITTEE ON PEDIATRICS

The sub-committee approached its review by way of posing various hypotheses. In general, these hypotheses considered the needs of children throughout the Province of Manitoba and the requirement for services in Winnipeg. In general, the work of the sub-committee could be discussed according to the following headings:

- Consolidation of facilities in Winnipeg;
- Preventive services;
- Ambulatory care needs;
- Requirement for neonatal and pediatric intensive care;
- Use of disciplines other than medicine;
- Rehabilitation services; and,
- Provincial programs.

After reviewing the information on the number of children predicted over the upcoming decade, the sub-committee recommended the consolidation of pediatric services at the Children's Centre and the St. Boniface General Hospital. In support of this recommendation was the prediction that the fertility rate of child-bearing women will continue to decline leading to a reduction in the number of children in Manitoba. The reduction in the need for in-patient services was also supported by a commitment to the expansion of preventive services, and in the proposed increase in ambulatory care facilities. It was the opinion of sub-committee members that by concentrating on prevention, and by deciding to provide a variety of treatments on an ambulatory care basis, there would be a decreasing need for in-patient services.

With regard to neonatal and pediatric intensive care, the sub-committee recommended consolidation of this service within one facility, that being the Children's Centre. To support critically ill neonates and children, the sub-committee also recommended the establishment of a provincial transportation system.

It was acknowledged that the training, recruitment and retention of neonatologists was a difficulty experienced in all provinces and to overcome this shortage, there should be a commitment in Manitoba to train neonatal nurse clinicians.

Rehabilitation services for children were also investigated and the sub-committee concluded that there was an urgent need for pediatric rehabilitation services in the areas of physiotherapy, occupational therapy and speech therapy.

Finally, the sub-committee reviewed the role of provincial programs which might have an impact on reducing morbidity and mortality rates with a resultant reduction in health care costs. Included in this recommendation of the sub-committee was the need for an in-depth review of the use of pediatric services in rural Manitoba as the sub-committee noted hospitalization rates far in excess of the provincial average or what might have been expected given the population mix.

Health Services Review Committee Comments

In general, the Health Services Review Committee supported the consolidation of pediatric services within two centres in Winnipeg. The Committee also recognized that if the proposed expansion of preventive services and ambulatory care services is successful, eventually there may only be a requirement for one pediatric centre to provide services to children in Winnipeg and to those referred from outlying areas. The Committee questioned whether it was advantageous to establish the recommended two centres in tertiary facilities, or whether it might not be more advantageous to establish the second centre in a non-teaching hospital. The Committee also noted that there was a recommendation from the sub-committee on pediatrics to close the Rehabilitation Centre for Children, and this was thought to require additional study by the Manitoba Health Services Commission. Although there was not a demonstrated need for in-patient services, the ambulatory care facility of the Rehabilitation Centre for Children was considered to be of benefit in the development of ambulatory services for the province. The Health Services Review Committee supported the commitment to preventive health activities, as well as the proposed increase in ambulatory care services. With regard to the recommendation to consolidate neonatal and pediatric intensive care services within two centres, this received the support of the Health Services Review Committee. Also the Committee acknowledged that the introduction of the Provincial Air Ambulance service would go far towards meeting the provincial transportation needs for critically ill individuals. The proposal to develop neonatal nurse clinicians was supported in-principle by the Health Services Review

Committee. However, the disposition of this recommendation is seen to be more appropriately referred to educational institutions and program sponsors. Rehabilitation needs for children are generally recognized to be a problem and the Health Services Review Committee recommends that a provincial study dealing with the long-term rehabilitation needs of Manitobans and the requirement for rehabilitative professionals be commissioned by the Manitoba Health Services Commission.

SUB-COMMITTEE ON RESPIRATORY DISORDERS

The sub-committee concluded that the incidence of respiratory disorders will gradually increase (with an aging population) and that treatment methods will undergo little change during the next decade. The sub-committee observed that the incidence of upper respiratory infections was frequent and was not likely to change. The theme of the sub-committee report provided a focus on the large demand of respiratory services from the elderly population. It was observed that elderly respiratory patients tie up many Winnipeg acute hospital beds inappropriately. The sub-committee defined that the most important known avoidable cause of respiratory disease is smoking, causing at least 90% of lung cancer and chronic obstructive pulmonary disease.

The sub-committee noted that continuous oxygen therapy is only provided in extended treatment hospitals. The sub-committee urged that such patients should be placed in a personal care home based on nursing time required. The sub-committee recommended that patient ventilation be authorized for use in personal care homes.

The sub-committee emphasized the excellence of the existing home care program and noted the service it provided to patients with respiratory disorders. It was observed that home care caseloads have become excessively large creating the problem that patient's home care plans tend to be reviewed only in moments of crisis. The sub-committee recommended that home care staffing be expanded to reduce caseloads and permit improved monitoring of home care clients.

The sub-committee emphasized that acute hospital beds should not be tied up for diagnostic respiratory tests as occurs now in Winnipeg. The sub-committee suggested that incentives be developed for greater hospital efficiencies to achieve shorter length of hospital stay for respiratory patients. The committee recommended that additional extended treatment hospital beds should be constructed to free up existing acute hopsital beds.

Health Services Review Committee Comments

The Health Services Review Committee concurred with the recommendations listed above to permit ventilation of patients in personal care homes, to decrease home care caseloads, and to expand the number of extended treatment hospital beds. However, the Health Services Review Committee refused to accept the assumption of a shortage of personal care home beds.

SUB-COMMITTEE ON THE TERMINALLY ILL

The sub-committee reviewing services to terminally ill patients focused their analysis on three major areas of the organization of the work:

1. The process of identification of terminal patients;
2. The need to involve care providers and patient advocate groups in discussion regarding the rights of patients to be informed of their diagnosis and prognosis, and to be involved in the decision-making process for intervention; and,
3. The requirement for reorganization of services for terminally ill patients based on existing models.

The sub-committee noted the difficulty of defining patients as terminal. Therefore, the task force concentrated their work on services to cancer patients. The tendency to intervene aggressively in the care of the terminally ill patient was noted as a service dilemma. The sub-committee recommended involving the College of Physicians and Surgeons to establish clarification regarding management of terminal illness. The committee observed that "approximately one-fifth of health care expenditures in the United States are taken up by the cost of caring for patients who are terminally ill with cancer, and for those who do not survive after treatment in critical or intensive care units." Part of the difficulty in organizing services was identified in the fact that "terminal illness is uncertain, stressful, discouraging, demoralizing, alienating....."

The issue of the involvement of the terminally ill patient in the planning for the receipt of health services was examined by the sub-committee. Currently, the determination of when and if a patient will be informed of terminal illness and offered the opportunity to be involved in a variety of decisions, rests with the individual physician. The sub-committee recommended that the issue of patient autonomy and rights to information be referred to the Manitoba Health Organizations to "encourage and help Boards develop and implement procedures to promote autonomy."

The sub-committee's report also focused on the organization of care for those individuals who are terminally ill, and provided guidelines for reorganization of health services within Winnipeg, Brandon and rural Manitoba. The recommendations included the organization of services in dedicated units and staffing by trained and experienced personnel.

In rural Manitoba (outside of Winnipeg and Brandon) the numbers of individuals suffering from terminal illness was not large enough to warrant the reorganization of hospital units into dedicated beds for the care of the terminally ill. With regard to Winnipeg, the sub-committee recommended that two 24-bed units be designated at the Health Sciences Centre and Municipal Hospitals, in addition to the unit at the St. Boniface General Hospital, for the care of terminally ill patients. With the exception of the unit at the St. Boniface General Hospital which has dedicated beds for the care of the terminally ill, patients in other centres are now grouped at random throughout Winnipeg hospitals. With regard to services in the Westman region, the sub-committee recommended that 12 dedicated beds be established in the Assiniboine Centre in Brandon for care of the terminally ill.

The report of the sub-committee on care to the terminally ill, like several other sub-committee reports, emphasized the very positive impact that the Continuing Care Program has had on the lives of individuals, and stressed the need to expand this area of service delivery. Because the need for service to those who are terminally ill is not restricted to any given day or any given shift of personnel, it was recommended that a float pool of nurses be available for the care of those who are terminally ill. This availability of services was not seen to be more expensive than the provision of services within hospital.

Health Services Review Committee Comments

The sub-committee provided information with regard to the need to establish a hospice for the treatment of those individuals who are stable and terminally ill, but the recommendation to create the hospice as an addition to the number of institutional places available for care of terminally ill patients was not accepted. Members of the Health Services Review Committee believe there are sufficient institutional beds available for the care of Manitobans, and that such expansion in service delivery should be facilitated from within existing resources.

The sub-committee recommended establishment of day hospital programs for the support of those who are terminally ill, and this general area regarding the expansion of day hospital programs received support in general by the Health Services Review Committee and will be discussed as it applies to other sub-committee reports.

Finally, with regard to the recommendations concerning the issues of whether the units for the care of the terminally ill should be closed or open admission units, these and other administrative details were considered by the Health Services Review Committee to be within the purview of staff members of the Manitoba Health Services Commission and the facilities in question.

SUB-COMMITTEES' RECOMMENDATIONS GROUPED BY ISSUE AND DISPOSITION

INDEX

I. IMPROVEMENT IN CURRENT SERVICES (QUALITY ASSURANCE/ENHANCEMENT)

   A) Diagnostic and treatment equipment (replace and/or add)
   B) Manpower (increase number and/or improve education)
   C) Administrative/organizational
   D) Service
   E) Physical resources

II. COST EFFECTIVE ALTERNATIVES

   A) Ambulatory diagnostic services
   B) NFA treatment/care
   C) Manpower substitution
   D) Bed reallocation
   E) Admission review/discharge planning
   F) Community-based services

III. SYSTEM REORGANIZATION

   A) Consolidation of services
   B) Regionalization of services
   C) Provincial programs
   D) Planning
   E) Administrative efficiencies
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IV. COMMUNICATION

   A) Professional
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V. INFORMATION REQUIRED

   A) Issue to be studied
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VI. POLICY REVIEW AND DEVELOPMENT

   A) Standards, criteria, evaluation guidelines
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VII. DEMONSTRATION PROJECTS

   A) Service
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VIII. PHASE-OUT/CLOSE

IX. ENDORSEMENT OF PRESENT POLICY/PRACTICE

SUB-COMMITTEES' RECOMMENDATIONS GROUPED BY ISSUE AND DISPOSITION

RECOMMENDATIONS AND DISPOSITIONS

I. A) Diagnostic and Treatment Equipment (replace and/or add)

The Cardiovascular Disorders Sub-Committee recommended that all major diagnostic and therapeutic facilities for congenital heart problems should be updated and expanded, preferably in one major tertiary care institution which at the present time is at the Children's Centre, Health Sciences Centre.

DISPOSITION: Refer to the Cardiac Advisory Committee
(Also related to System Reorganization, Consolidation of Services)

The Gastrointestinal Diseases Sub-Committee recommended that ultrasound facilities must be more widely distributed throughout the province (both hospital-based and non-hospital-based).

DISPOSITION: Refer to the Ultrasound Advisory Committee
(Also related to Improvement in Current Services, Service)

The Gastrointestinal Diseases Sub-Committee recommended that in-hospital availability of C.T. scanning must be improved in the province (to a minimum of 1,200,000 population) to facilitate its use in patients with non-central nervous system problems.

DISPOSITION: Refer to the Computed Tomography Advisory Committee
(Also related to Improvement in Current Services, Service)

The Gastrointestinal Diseases Sub-Committee recommended that both in-hospital and private office availability of ultrasound must be improved in the province.
DISPOSITION: Refer to the Ultrasound Advisory Committee

The Gastrointestinal Diseases Sub-Committee recommended that the province must be prepared to introduce Nuclear Magnetic Resonance Scanning (NMR or MR Imaging) if it meets its early expectations as a superb diagnostic tool in certain circumstances.
DISPOSITION: Expand the Computed Tomography Advisory Committee

The Gastrointestinal Diseases Sub-Committee recommended that provision must be made for the replacement of rigid sigmoidoscopy by flexible fiberoptic sigmoidoscopy in some private offices and "regional centres."
DISPOSITION: Refer to the Manitoba Health Services Commission, Facilities Division

The Not-For-Admission Surgery Sub-Committee recommended that while day surgery is well underway in some Manitoba hospitals, an expansion to other hospitals requires necessary back-up services.
DISPOSITION: Consider with ambulatory services funding (see Volume 1, page 14)
(Also related to Improvement in Current Services, Physical Resources)

The Obstetrics Sub-Committee recommended that the availability of ultrasound services must be improved to allow for more free and immediate access, thus avoiding the necessity of admitting patients to hospital to have ultrasound done. In this regard the current plan to expand ultrasound facilities in the province must be actively pursued.

DISPOSITION: Refer to the Ultrasound Advisory Committee
(Also related to Improvement in Current Services, Service)

The Obstetrics Sub-Committee recommended that funding must be provided for equipment for self-monitoring programs (e.g. - electronic sphygmomanometer and glucometer).

DISPOSITION: Refer to the Manitoba Health Services Committee, Facilities Division

The Oncology Sub-Committee recommended that provision should be made for a second high energy linear accelerator and replacement of the existing 4MEV linear accelerator.

DISPOSITION: Refer to the Manitoba Health Services Committee, Facilities Division

The Oncology Sub-Committee recommended that a simulator be installed at the St. Boniface General Hospital oncology unit.

DISPOSITION: Refer to the Manitoba Health Services Committee, Facilities Division

The Out-Patients Sub-Committee recommended that out-patient departments have ready access to the sophisticated diagnostic and therapeutic equipment, support services, and support personnel within the teaching hospital.

DISPOSITION: Refer to the Provincial Diagnostic Review Committee
(Also related to Cost Effective Alternates, Ambulatory Diagnostic Services)

The Respiratory Sub-Committee recommended that upgrading of diagnostic facilities for expanded ambulatory care is required to reduce waiting time for diagnostic services. In-patient admissions to the Respiratory Centre could be reduced by current unnecessary admissions simply by having access to required diagnostic procedures.

DISPOSITION: Consider within ambulatory services funding (see Volume I, page 14).

I. B) Manpower (increase number and/or improve education)

The Continuing Care Sub-Committee recommended that the need for a basic staff-to-workload ratio for assessment/care planning be recognized; that assessment/care planning staff positions be released from staff reduction/freeze policies; that adequate term time be made available to cover extended absences.

DISPOSITION: Recommend to the Deputy Minister of Health (Also related to System Reorganization, Funding)

The Critical Care Sub-Committee recommended that the current intensive care bed capaicty, particularly in the City of Winnipeg, should be increased in the short-term by: a) efforts to recruit adequate numbers of intensive care nurses; b) an increase in funded positions for intensive care nurses; and, c) implementation of funding for Hospital Medical Officers.

DISPOSITION: Refer to the Manitoba Health Services Commission

The Sub-Committee on Services for the Elderly recommended that all undergraduate students from the health and social service field, should receive instruction on both normal and abnormal aging, as well as an introduction to the health care delivery system. Practice opportunities should be developed in order to encourage a positive interest in working in this area.

DISPOSITION: Recommend to the University of Manitoba Faculties

The Sub-Committee on Services for the Eldery recommended that Manitoba Health allocate sufficient resources to enable the Continuing Care Program to fulfill its existing mandate in light of increasing workloads, both in terms of numbers and complexity. A staffing-to-workload ratio should be established along with mechanisms that ensure minimum staffing is guaranteed at all times for the coordination and delivery of service.
DISPOSITION: Recommend to the Deputy Minister of Health

The Sub-Committee on Services for the Elderly recommended that expansion of Adult Day Care as a resource to the Continuing Care Program requires a reduction of the caseload ratio for case coordinators and an immediate response to filling staff vacancies occurring through attrition.
DISPOSITION: Recommend to the Deputy Minister of Health
(Also related to Cost Effective Alternatives, Community-Based Services)

The Emergency Health Care Sub-Committee recommended that training for prehospital care should be standardized and hospital-based. Rural hospitals in excess of 60 beds should have an ambulance personnel standard at the CMA I level. Rural hospitals less than 60 beds should have ambulance personnel training standards at the first responder level.
DISPOSITION: Refer to the Manitoba Health Services Commission, Director of Rural Facilities and Ambulance Services

The Emergency Health Care Sub-Committee recommended that in hospitals larger than 60 beds, physicians and nurses involved in emergency care should be trained in ACLS and ATLS courses.

DISPOSITION: Refer to the Manitoba Health Services Commission, Director of Rural Facilities and Ambulance Services

The Gastrointestinal Diseases Sub-Committee recommended that upper gastrointestinal endoscopy, by skilled endoscopists, should be more widely available in the province.

DISPOSITION: Refer to the Standing Committee on Medical Manpower
(Also related to Improvement in Current Services, Service)

The Gastrointestinal Diseases Sub-Committee recommended that facilities must be developed and skilled physicians/surgeons must be located in strategic regionalized centres in the province.

DISPOSITION: Refer to the Standing Committee on Medical Manpower.

The Indian Health Care Sub-Committee recommended that both governments should seek ways to increase training opportunities to enable Indians to assume responsibilities as health program planners, health professionals and health para-professionals.

DISPOSITION: Recommend to the governments of Manitoba and Canada.

The Indian Health Care Sub-Committee recommended that health care personnel should be orientated to their role and responsibilities in isolated and cross-cultural settings.

DISPOSITION: Recommend to Health and Welfare, Medical
Services Branch

The Indian Health Care Sub-Committee recommended that an adequate training course for nurse practitioners to work in isolated locations should be developed.

DISPOSITION: Recommend to Health and Welfare, Medical
Services Branch

The Indian Health Care Sub-Committee recommended that both the training level and staffing for interpreters in hospitals should be increased.

DISPOSITION: Refer to the Manitoba Health Services
Committee, Facilities Division

The Obstetric Sub-Committee recommended that free access to out-patient perinatal assessment facilities must be made available to patients throughout the province by providing fetal assessment units staffed with appropriately trained nurses and supervised by obstetricians in Winnipeg and regional centres.

DISPOSITION: Refer to the Manitoba Health Services
Committee, Facilities Division

The Obstetric Sub-Committee recommended that a program should be established in Manitoba immediately to educate nurses to assume the role of neonatal nurse clinicians in order to meet the urgent manpower needs of the two tertiary care centres.

DISPOSITION: Refer to the Health Sciences Centre, St. Boniface General Hospital, Manitoba Health Services Commission for discussion

The Obstetric Sub-Committee recommended that all hospitals offering obstetric services should have in-house skills for infant resuscitation and stabilization at the time of delivery.

DISPOSITION: Refer to the College of Physicians and Surgeons of Manitoba
(Also related to Improvement in Current Services, Diagnostic and Treatment Equipment)

The Obstetric Sub-Committee recommended that such skills should be provided either through the availability of a 24-hour anesthesia service (with an appropriate retention fee) or appropriate training should be provided to equip designated physicians, nurses or respiratory technologists to perform these functions.

DISPOSITION: Refer to the College of Physicians and Surgeons of Manitoba

The Obstetric Sub-Committee recommended that a viable professional educational program be developed to support in-patient obstetric services.

DISPOSITION: Recommend that the Maternal and Child Health Directorate discuss

The Obstetric Sub-Committee recommended that educators should be trained and licensed.

DISPOSITION: Refer to the College of Physicians and Surgeons of Manitoba and the Manitoba Association of Registered Nurses

The Oncology Sub-Committee recommended that the complement of radiation oncologists should be immediately increased from seven to nine.

DISPOSITION: Refer to the Manitoba Health Services Commission, Facilities Division

The Oncology Sub-Committee recommended that direct funding should be provided for a residency program of six residents or fellows for a least the next five years or until a continuing full complement of radiation oncologists within the province is assured.

DISPOSITION: Refer to the University, the Manitoba Cancer Treatment and Research Foundation and the Manitoba Health Services Commission to discuss

The Oncology Sub-Committee recommended that radiotherapy expertise and availability must be improved.

DISPOSITION: Refer to the Manitoba Cancer Treatment and Research Foundation and Manitoba Health Services Commission to discuss

The Oncology Sub-Committee recommended that a physician education program and a public education program with a screening component be implemented for the early detection and prevention of endometreal and ovarian carcinoma.

DISPOSITION: Refer to the Manitoba Cancer Treatment and Research Foundation and Manitoba Health Services Commission to discuss (Also related to Communication, Public Education)

The Oncology Sub-Committee recommended that there is an unacceptable delay in surgical scheduling for gynecological oncological surgery at the Health Sciences Centre which can be shortened by staffing existing operating room facilities.

DISPOSITION: Refer to the Administrative Impacts Sub-Committee

The Oncology Sub-Committee recommended that consideration be given to increased staffing for simulation, treatment planning, and the servicing of radiation oncology consistent with the expansion of that section.

DISPOSITION: Refer to the Manitoba Cancer Treatment and Research Foundation and the Manitoba Health Services Commission

The Oncology Sub-Committee recommended that oncology nursing be developed in this province as a specialty to produce improved patient care in both out-patient and in-patient settings.

DISPOSITION: Refer to the University, the Manitoba Cancer Treatment and Research Foundation and Manitoba Association of Registered Nurses

The Oncology Sub-Committee recommended that there be a larger role in public education and cancer prevention programs for nurses.

DISPOSITION: Refer to the Manitoba Cancer Treatment and Research Foundation and the Manitoba Association of Registered Nurses

The Oncology Sub-Committee recommended that in-patient oncology nursing could be markedly improved by special training and the concentration of these nurses on specialized dedicated oncology wards.

DISPOSITION: Refer to the Administrative Impact Sub-Committee to discuss the concept of dedicated beds

The Out-Patients Sub-Committee recommended that out-patient departments develop a multidisciplinary approach to patient care.

DISPOSITION: Recommend that the Manitoba Health Services Commission initiate a pilot project

The Out-Patients Sub-Committee recommended that as model ambulatory care facilities, out-patient departments in the teaching hospitals should be used to provide teaching and experience for undergraduate and graduate medical trainees, nurses, allied health care professionals, and hospital administrators.

DISPOSITION: Recommend that the University and the Health Sciences Centre initiate a pilot project

The Out-Patients Sub-Committee recommended that undergraduate medical education in Manitoba should emphasize the ambulatory setting as the major location for provision of medical care. All health care providers should be trained to work cooperatively to treat and maintain patients without hospitalization where possible.
DISPOSITION: Recommend that the University and the Health Sciences Centre initiate a pilot project

The Respiratory Disorders Sub-Committee recommended that the caseloads of the Continuing Care staff should be reduced to permit continuous program assessment (other than only in moments of crises).
DISPOSITION: Recommend to the Deputy Minister of Health

I. C) Administrative/Organizational

The Sub-Committee on Services for the Elderly recommended that all hospitals develop specific strategies to improve their own clinical resources for elderly patients and include mechanisms for linkage with appropriate community resources.

DISPOSITION: Refer to the Manitoba Health Services Commission, Facilities Division

The Emergency Health Care Sub-Committee recommended that a Medical Director should be appointed to standardize the delivery of emergency care, including the most appropriate method of transportation.

DISPOSITION: Manitoba Health Services Commission appointment of a Medical Director has been finalized
(Also related to Improvement in Current Services, Manpower)

The Indian Health Care Sub-Committee recommended that there should be regular and adequately resourced meetings between the governments of Manitoba and Canada and the Indian community of Manitoba.

DISPOSITION: Refer to the governments of Manitoba and Canada
(Also related to System Reorganization, Planning)

The Indian Health Care Sub-Committee recommended that local communities should be involved in the recruitment, selection, and retention of health care personnel.

DISPOSITION: Table this recommendation, pending the outcome of tripartite negotiations

The Obstetric Sub-Committee recommended that public health nurses should have skills and knowledge upgraded and updated in obstetrics and neonatology for participation in this program; they should have a close working relationship with the hospital(s) and a public health nurse coordinator should be situated in each hospital.

DISPOSITION: Recommend to the Deputy Minister of Health (Also related to Improvement in Current Services, Manpower)

I. D) Service

The Continuing Care Sub-Committee recommended that the need for proportional support for services, which can prompt the need for formalized care services, be recognized (eg. - support services for elderly; health promotion).
DISPOSITION: Refer to Manitoba Health

The Critical Care Sub-Committee recommended that the Manitoba Health Services Committee move as rapidly as possible to implement the recommendations of the College of Physicians and Surgeons of Manitoba Report on Transport and Northern Medical Services.
DISPOSITION: Refer to the Manitoba Health Services Commission

The Sub-Committee on Services for the Elderly recommended that the province should continue a planned expansion of the adult day care resource, paying particular attention to the areas of the province not now served, as well as special needs programs (e.g. - for the cognitively impaired and younger disabled adult). Free standing or non-institutional locations and sponsors are required.
DISPOSITION: Recommend to the Director of Long-Term Care (Also related to Cost Effective Alternates, Community-Based Services)

The Sub-Committee on Services for the Elderly recommended that where the density of seniors in the population is high (20% of the population 60+ and/or numbers are substantial), a Senior Centre should be established to provide socializing opportunities and services to meet the needs and enhance the quality of the lives of the elderly population in the community.

DISPOSITION: Refer to the Provincial Gerontologist
(Also related to Policy Review and
Development, Standards, Criteria, Evaluation
Guidelines)

The Sub-Committee on Services for the Elderly recommended that in areas where there are not currently health promotion programs which incorporate surveillance of the frail and at-risk elderly, Senior Centres should be requested to perform this function.

DISPOSTION: Refer to the Provincial Gerontologist
(Also related to Policy Review and
Development, Standards, Criteria, Evaluation
Guidelines)

The Gastrointestinal Diseases Sub-Committee recommended that double contrast gastrointestinal radiologic examinations must be more widely available within the province.

DISPOSITION: Refer to the Laboratory and X-Ray Services
Division of the Manitoba Health Services
Commission

The Gastrointestinal Diseases Sub-Committee recommended that endoscopy, particularly flexible colonoscopy by skilled endoscopists, should be more widely available in the province for diagnosis, prevention, and therapy of localized disease.

DISPOSITION: Refer to the Sub-Committee on Medical
Manpower

The Gastrointestinal Diseases Sub-Committee recommended that double contrast or better quality gastrointestinal barium studies must be available throughout the province.

DISPOSITION: Refer to the Sub-Committee on Medical Manpower
(Also related to Improvement in Current Services, Diagnostic and Treatment Equipment)

The Gastrointestinal Diseases Sub-Committee recommended that intra-operative radiology must be improved in major hospitals to improve operative management of biliary tract disease.

DISPOSITION: Refer to the Sub-Committee on Administrative Impacts

The Gastrointestinal Diseases Sub-Committee recommended that routine colonoscopy with biopsy must be promulgated in the follow-up of patients with ulcerative colitis--another impetus for regionalized expertise in endoscopy.

DISPOSITION: Refer to the Sub-Committee on Administrative Impacts
(Also related to Policy Review and Development, Standards, Criteria, Evaluation Guidelines)

The Gastrointestinal Diseases Sub-Committee recommended that a fee schedule must be developed to allow payment for interventional procedures carried out with the use of C.T. scanning (biopsy, drainage, etc.)

DISPOSITION: Refer to the Manitoba Health Services Commission and the Manitoba Medical Association for discussion

The Gastrointestinal Diseases Sub-Committee recommended that an appropriate fee schedule must be developed to allow diagnostic endoscopy to develop in private offices, leaving hospital facilities less congested and more specifically prepared for therapeutic endoscopy (which may require radiologic assistance and/or operating room backup)

DISPOSITION: Refer to the Manitoba Health Services
Commission and the Manitoba Medical
Association for discussion

The Gastrointestinal Diseases Sub-Committee recommended that an appropriate fee schedule and easy access must be developed to encourage use of flexible sigmoidoscopy for diagnosis and therapeutic services.

DISPOSITION: Refer to the Manitoba Health Services
Commission and the Manitoba Medical
Association

The Indian Health Care Sub-Committee recommended that there should be improvements made in the out-of-hospital accommodations available to Inuit patients in Churchill and Winnipeg. The proposal of the Keewatin Inuit Association to have an Inuit health commission review the health services in the Keewatin district should be supported.

DISPOSITION: Refer to the Sub-Committee on Administrative
Impacts
(Also related to System Reorganization,
Regionalization of Services)

The Obstetric Sub-Committee recommended that fetal assessment by real time ultrasound should always be done as part of a more general perinatal assessment as ultrasound findings taken in isolation may be misleading. This should be the responsibility of an individual with sufficient obstetric experience to provide consultative perinatal advice and education.

DISPOSITION: Refer to the College of Physicians and Surgeons of Manitoba

The Obstetric Sub-Committee recommended that diabetes education and monitoring programs should be available and freely accessible to all women, pregnant or non-pregnant, at both tertiary care centres and in regional centres. Programs dealing with pregnant diabetics should be staffed by internists who have training, knowledge, experience and a special interest in managing diabetes in pregnancy.

DISPOSITION: Refer to the Maternal and Child Health Directorate
(Also related to System Reorganization, Regionalization of Services)

The Obstetric Sub-Committee recommended that a perinatal air and ground ambulance evacuation system should be made available throughout the province for maternal transfer and for transport of the neonate when the delivery of a compromised baby in a rural area has been unavoidable.

DISPOSITION: Refer to the Manitoba Health Services Commission, Air Ambulance Service

The Obstetric Sub-Committee recommended that postpartum care and education in hospital prior to discharge should be provided by dedicated nursing personnel. Steps must be taken to ensure the education of nurses to carry out these specialized functions in maternal and child health.

DISPOSITION: Refer to the Manitoba Health Services Commission, the University of Manitoba, and the Director of Maternal and Child Health

The Obstetric Sub-Committee recommended that provision must be made to include in these follow-up programs services and therapies required by high-risk infants to allow them to develop to their full potential as individuals.

DISPOSITION: Refer to the Manitoba Health Services Commission, the Health Sciences Centre and St. Boniface General Hospital for discussion.

The Obstetric Sub-Committee recommended that the current neonatal transport system should be extended to serve the whole of the Province of Manitoba.

DISPOSITION: Refer to the Manitoba Health Services Commission, Air Ambulance Division

The Obstetric Sub-Committee recommended that education should extend through the prenatal, perinatal and postnatal periods, extending into the eleventh month.

DISPOSITION: Refer to Manitoba Health, Maternal and Child Health Directorate

The Obstetric Sub-Committee recommended that where it is practical, an attempt should be made to have the same instructor remain with the patient throughout.

DISPOSITION: Refer to Manitoba Health, Maternal and Child Health Directorate

The Obstetric Sub-Committee recommended that the goal must be to enroll all patients, both primigravida and multipara, as standards change and patients' circumstances change from pregnancy to pregnancy.

DISPOSITION: Refer to Manitoba Health, Maternal and Child Health Directorate

The Obstetric Sub-Committee recommended that child support should begin with the patient's first prenatal visit and/or prenatal class.

DISPOSITION: Recommend to the government of Canada

The Obstetrics Sub-Committee recommended that diabetes education programs should be available and freely accessible to all women, pregnant and non-pregnant, at both tertiary care centres and in regional centres.

DISPOSITION: Refer to Manitoba Health, Maternal and Child Health Directorate

The Oncology Sub-Committee recommended that should the National Cancer Institute Study on Breast Screening indicate that screening is an effective method of early detection that the present pilot screening program be retained and expanded.

DISPOSITION: Supported by the Health Services Review Committee

The Oncology Sub-Committee recommended that the expansion of volunteer services throughout the province can be an effective means of improving patient support services and reducing costs.

DISPOSITION: Supported by the Health Services Review Committee and referred to the Sub-Committee on Administrative Impacts for action

The Pediatric Sub-Committee recommended that a total provincial transport system should be developed for critically ill patients.

DISPOSITION: Refer to the Manitoba Health Services Commission, Air Ambulance Program

The Terminally Ill Sub-Committee recommended that urban home care services be augmented with a new category of home care nursing: a float pool of nurses to provide continuous attendance at the dying patient's home during the last hours of life.

DISPOSITION: Refer to the Continuing Care Program and Manitoba Health Services Commission Long-Term Care Program

I. E) Physical Resources

The Continuing Care Sub-Committee recommended that rather than modifying (increasing) cost limits and service limits, alternative approaches be developed to respond to clients requiring service/care of a level greater than that provided by Home Care and of a level less than that existing in institutions (e.g. - group living and special care arrangements).

DISPOSITION: Supported by the Health Services Review Committee and referred to the Sub-Committee on Administrative Impacts for action

The Sub-Committee on Services for the Elderly recommended that for the 'high risk' elderly who wish to retain their independence, there should be a specialized form of housing where programs, meals, and personal assistance are available on a 24 hour basis. Such accommodation should include wheelchair accessible and adapted units, and could utilize shared staff where there is justaposition or proximity to another facility, e.g. - a personal care home.

DISPOSITION: Supported by the Health Services Review Committee and referred to the Manitoba Health Services Commission
(Also related to Improvement in Current Services, Service, and to Cost Effective Alternates, Community-Based Services)

The Sub-Committee on Services for the Elderly recommended that implementation of government policy on multipurpose Senior Centres will require the establishment of a pool of capital resources for construction and renovation of Senior Centres. Such capital should only be available to Centres that agree to meet C.I.S.C. standards. The highest degree of accessibility to the total aging community can be achieved if the Centres are free standing in visible locations rather than co-located in Elderly Persons' Housing buildings.

DISPOSITION: Supported by the Health Services Review Committee and referred to the Manitoba Health Services Commission
(Also related to System Reorganization, Community-Based Services)

The Obstetric Sub-Committee recommended that free access to out-patient perinatal assessment facilities must be made available to patients throughout the province by providing hostel accommodation in Winnipeg with frequent visits to fetal assessment units in either the Health Sciences or St. Boniface for patients from more remote areas.

DISPOSITION: Supported by the Health Services Review Committee and referred to the Manitoba Health Services Commission, the Health Sciences Centre and St. Boniface General Hospital for discussion

The Obstetric Sub-Committee recommended that hostel accommodations should be provided at the two tertiary care hospitals for postpartum patients as an insured service to allow early discharge of out-of-town patients with their babies with visitation by early discharge nurses where these services are not available in the community and to allow discharge of out-of-town mothers whose babies are detained in the nurseries allowing frequent visiting and bonding. Consideration should also be given to the need for provision of hostels or boarding house networks as an insured service in association with regional hospitals. Prenatal education and social services should be available to patients in these situations. For diabetic patients, dietary services should be available either in the hostel or by allowing the patient access to the cafeteria and dietary service in the nearby hospital. This hostel would be largely for the use of displaced rural patients and would avoid the necessity of using hospital beds for boarding purposes.

DISPOSTION: Refer to the Manitoba Health Services Commission, the Health Sciences Centre, and St. Boniface General Hospital
(Also related to Improvement in Current Services, Service, and to System Reorganization, Funding)

The Obstetric Sub-Committee recommended that the proposed increase in neonatal intensive care beds should proceed as a matter of urgency to achieve a minimum of 31 between the two high-risk centres, this number to be adjusted from time to time as birth rates fluctuate to maintain the minimum required number.

DISPOSITION: Refer to the Manitoba Health Services Commission, the Health Sciences Centre, and St. Boniface General Hospital for discussion

The Obstetric Sub-Committee recommended that first priority should be given to upgrading and expansion of the perinatal units at the Health Sciences Centre and St. Boniface General Hosptial to accommodate up to 4,500 deliveries per year at each unit with provision for both high-risk and family-centered care.

DISPOSITION: Refer to the Manitoba Health Services Commission, the Health Sciences Centre, and St. Boniface General Hospital for discussion

The Oncology Sub-Committee recommended that there is an urgent need for dedicated medical oncology beds at the Manitoba Cancer Treatment and Research Foundation site. Planning should go forward immediately to establish a permanent facility for this group of in-patients.

DISPOSITION: The Health Services Review Committee disagrees, noting the context of other recommendations

The Oncology Sub-Committee recommended that there is an urgent need for a radiation oncology in-patient unit at the Manitoba Cancer Treatment and Research Foundation site to house patients receiving external radiation and brachytherapy. This should be done in immediate juxtaposition to a medical oncology unit and could be done on a ward combining radiation oncology patients with surgical and/or gynecological patients.

DISPOSITION: Refer to the Manitoba Health Services Commission, and the Manitoba Cancer Treatment and Research Foundation for discussion

The Oncology Sub-Committee recommended that the Surgical Oncology Section at the Manitoba Cancer Treatment and Research Foundation and affiliated units be expanded.

DISPOSITION: Refer to the Manitoba Health Services Commission, and the Manitoba Cancer Treatment and Research Foundation for discussion

The Oncology Sub-Committee recommended that provision of surgical oncology beds be provided in conjunction with those of radiation oncology.

DISPOSITION: Refer to the Sub-Committee on Administrative Impacts

The Terminally Ill Sub-Committee recommended that a hospice for stable terminally ill patients be established who do not have a home in which to be cared for.

DISPOSITION: Supported by the Health Services Review Committee and referred to the Sub-Committee on Administrative Impacts

II. Cost Effective Alternatives

II. A) Ambulatory Diagnostic Services

The Cardivascular Disorders Subcommittee recommended that analysis of invasive cardiac investigative and diagnostic problems indicates that the anticipated caseload in Manitoba will be at around 1,500-1,600 patients per year. Since approximately 30-35% of these patients, with less complex procedures could be done on NFA (Not For Admission) basis, proper facilities for this should be established in institutions involved in these functions. This is relevant to physical space, monitoring resources, staffing, high quality nursing and professional availability. This in itself should reduce the cost for these procedures related to hospitalization since at the present time all of them are done on an in-hospital basis. It would also provide a more convenient service for the patients.

DISPOSITION: Supported by the Health Services Review Committee within funding limits of the $17.5M (see Volume I, page 14)

The Sub-Committee on Services for the Elderly recommends that there be optimal use of geriatric assessment and consultation (not necessarily requiring in-patient status) in order to obtain complete assessment of individual needs, guide subsequent management and reduce inappropriate use of institutional resources.

DISPOSITION: The Health Services Review Committee supports the principle

The Oncology Sub-Committee recommended increasing and upgrading the ambulatory services at the Manitoba Cancer Treatment and Research Foundation and the St. Boniface General Hospital oncology units to encompass new techniques and support services.

DISPOSITION: Supported by the Health Services Review Committee within funding limits of the $17.5M (see Volume I, page 14)

The Oncology Sub-Committee recommended that the NFA facility at the Manitoba Cancer Treatment and Research Foundation should be upgraded to allow its expanded use for biopsy and endoscopy thus reducing hospital admissions.

DISPOSITION: Supported by the Health Services Review Committee within funding limits of the $17.5M (see Volume I, page 14)

The Oncology Sub-Committee recommended that ambulatory resources should be increased. This is less expensive than reverting to in-patient care.

DISPOSITION: Supported by the Health Services Review Committee within funding limits of the $17.5M (see Volume I, page 14)

II. B) Not-For-Admission (NFA) Treatment/Care

The Gastrointestinal Sub-Committee recommended that facilities for NFA surgery must be improved throughout the province.

DISPOSITION: Supported by the Health Services Review Committee within funding limits of the $17.5M (see Volume I, page 14)

The Not-For-Admission Surgery Sub-Committee recommended that twelve categories of procedures should be done primarily as out-patient surgery. The reduced demand on hospital beds would provide an equivalent of approximately a 50-bed hospital.

DISPOSITION: Supported by the Health Services Review Committee within funding limits of the $17.5M (see Volume I, page 14)

The Obstetric Sub-Committee recommended that physicians should be encouraged to manage as many antepartum problems as possible on an ambulatory basis where this can be done with safety using the services identified ...

DISPOSITION: Supported by the Health Services Review Committee within funding limits of the $17.5M (see Volume I, page 14) (Also related to Cost Effective Alternates, Ambulatory Diagnostic Services, and to Communication, Professional)

The Obstetric Sub-Committee recommended that adequate funding and facilities should be provided for NFA programs with separate and dedicated recovery areas and beds.

DISPOSITION: Supported by the Health Services Review Committee within funding limits of the $17.5M (see Volume I, page 14)

The Obstetric Sub-Committee recommended that NFA programs should provide for emergency minor gynecology procedures.

DISPOSITION: Supported by the Health Services Review Committee within funding limits of the $17.5M (see Volume I, page 14)

The Obstetric Sub-Committee recommended that NFA units or surgicentres should have ready access to full hospital backup facilities.

DISPOSITION: Supported in principle by the Health Services Review Committee

The Obstetric Sub-Committee recommended that funding should be provided for specialty ambulatory programs such as cervical colposcopy and cryotherapy, ovum pic-up and embryo transfer and laser surgery.

DISPOSITION: Supported in principle by the Health Services Review Committee

The Oncology Sub-Committee recommended that the NFA facilities at the tertiary care hospitals be upgraded to reduce hospital admissions and length of hospital stay.

DISPOSITION: Supported by the Health Services Review Committee and referred to the Sub-Committee on Administrative Impacts

The Oncology Sub-Committee recommended that out-patient preventive programs for cancer of the cervix should be upgraded by an increased and more efficient Pap smear program with increased colposcopy, surgical and laser treatment facilities.

DISPOSITION: Refer to the Manitoba Health Services Commission and the Manitoba Cancer Treatment and Research Foundation
(Also related to Cost Effective Alternates, Ambulatory Diagnostic Services, and to Improvement in Current Services, Service)

The Out-Patients Sub-Committee recommended that the existing out-patient departments in Manitoba's major teaching hospitals should be developed and expanded as model ambulatory care facilities.

DISPOSITION: Supported by the Health Services Review Committee within funding limits of the $17.5M (Volume I, page 14)
(Also related to Improvement in Current Services, Service, and to Cost Effective Alternates, Ambulatory Diagnostic Services)

The Out-Patients Sub-Committee recommended that as model ambulatory care facilities, out-patient departments in the teaching hospitals should be used to develop and implement new types of out-patient services.

DISPOSITION: Supported by the Health Services Review Committee within the limits of the $17.5M (see Volume I, page 14)
(Also related to Cost Effective Alternates, Consolidation of Services, and to Improvement in Current Services, Service)

II. C) Manpower Substitution

The Cardiovascular Disorders Sub-Committee recommended that it is essential to continue to maintain high calibre nursing service in all areas related to cardiac care. Of equal importance is also nurse clinician personnel and the educational programs that are capable of producing this type of manpower. At the present time this function is very successfully practiced on Cardiovascular and Thoracic Surgical Services at St. Boniface General Hospital and at the Health Sciences Centre, where a good number of functions previously performed by other professionals are successfully fulfilled by these individuals with the same degree of expertise.

DISPOSITION: Refer to the Manitoba Health Services
Commission and University of Manitoba
(Also related to System Reorganization,
Provincial Programs)

The Obstetric Sub-Committee recommended that an ad hoc task force should be set up to study and make recommendations on the issue of the expansion of the role of the nurse in reproductive health care with particular reference to fetal assessment, neonatal intensive care, antepartum care and surveillence, nurse midwifery, screening for gynecologic disease and involvement in specialty areas such as infertility.

DISPOSITION: Recommend establishment of the ad hoc
committee

The Pediatric Sub-Committee recommended that a neonatal nurse clinician program should be implemented as soon as possible.

DISPOSITION: Refer to the Directors of Nursing of the St. Boniface General Hospital and the Health Sciences Centre

II. D) Bed Reallocation

The Continuing Care Sub-Committee recommended that consideration be given to establishing appropriately staffed convalescent beds so that the decision as to the locus of discharge can be delayed until such individuals recover sufficiently to permit a determination as to whether they should go home rather than to a nursing home.

DISPOSITION: Supported by the Health Services Review Committee within funding limits of the $17.5M (see Volume I, page 14)

The Continuing Care Sub-Committee recommended that some existing and new long-term hospital beds be specifically designated to care for persons requiring very heavy or specialized care, and consideration also be given to permitting some existing or new nursing homes to provide a few types of specialized care (e.g. - oxygen therapy/tube feeding) on an experimental basis on condition that they are outfilled and staffed appropriately. In view of the high occupancy rates of nursing homes, this innovation should be considered only as new nursing home beds become available.

DISPOSITION: The Health Services Review Committee did not support additional personal care home beds at this time.
Supported by the Health Services Review Committee within funding limits of the $17.5M (see Volume I, page 14)
(Also related to Policy Review and Development, Standards, Criteria, Evaluation Guidelines)

The Critical Care Sub-Committee recommended that reallocation of existing hospital beds for development of intermediary care, high dependency or step-down beds be undertaken. Such beds will provide for the more seriously ill of the ward patients without occupying intensive care beds.

DISPOSITION: Refer to the Manitoba Health Services Commission

The Sub-Committee on Services for the Elderly recommended that all hospitals in conjunction with the Manitoba Health Services Commission should review their allocation and service distribution of beds, paying particular attention to the incidence/prevalence of disease and the age structure of the population that they serve.

DISPOSITION: Supported by the Health Services Review Committee
(Also related to Policy Review and Development, Service Utilization Review)

The Sub-Committee on Services for the Elderly recommended that respite care resources should be expanded throughout the province. Expansion will accommodate more flexible scheduling and more immediate access.

DISPOSITION: Supported by the Health Services Review Committee within funding limits of the $17.5M (see Volume I, page 14)
(Also related to Improvement in Current Services, Service)

The Oncology Sub-Committee recommended that the St. Boniface General Hospital be encouraged to proceed as soon as possible with the establishment of a dedicated ward for oncology patients.

DISPOSITION: The Health Services Review Committee did not support additional beds. Refer to the Manitoba Health Services Commission, St. Boniface General Hospital, and the Manitoba Cancer Treatment and Research Foundation to discuss alternate use of beds

The Respiratory Sub-Committee recommended that alternative long-term care facilities should be an important part of the means to manage respiratory diseases for the elderly.

DISPOSITION: Refer to the Manitoba Health Services Commission

The Terminally Ill Sub-Committee recommended that there be improvement in alternative services for the terminally ill, mainly for cancer patients, by encouraging the redesignation of hospital beds to establish more palliative care units on the model of existing units, and utilizing existing units to prepare professional staff for appropriate care of the terminally ill.

DISPOSITION: Supported by the Health Services Review Committee

The Terminally Ill Sub-Committee recommended that four palliative care units be designated in Manitoba: 24-bed units at the Health Sciences Centre, the Municipal Hospitals and the St. Boniface General Hospital and a 12-bed unit at the Assiniboine Centre. In rural hospitals and urban hospitals with palliative care units, permit participation in the palliative care program by a hospital's indication of willingness to protect beds for the admission of terminally ill patients and by arranging appropriate preparation of staff on wards where beds will be used for the terminally ill. Palliative care should be based on a formal link, initiated by the primary physician, coordinated by the home care program and backed up by assured admission, in crisis, to an identified facility, either a palliative care unit or a hospital ward.

DISPOSITION: Supported by the Health Services Review Committee

II. E) Admission Review/Discharge Planning

The Continuing Care Sub-Committee recommended that discharge planning start upon admission to hospital or as soon thereafter as possible. If continuing clinical instability makes such early planning for specific individuals impossible, these persons may need to occupy an acute bed until they can be appropriately accommodated in the community.

DISPOSITION: Refer to the Sub-Committee on Administrative Impacts
(Also related to Policy Review and Development, Standards, Criteria, Evaluation Guidelines)

II. F) Community-Based Services

The Continuing Care Sub-Committee recommended that the Manitoba Health Services Commission and the Office of Continuing Care develop a written Admission Information Guide to be distributed in orienting physicians and other hospital personnel in responding to care issues of patients and families which arise at admission.

DISPOSITION: Refer to the Sub-Committee on Administrative Impacts
(Also related to Information Required, Issue to be Studied)

The Sub-Committee on Services for the Elderly recommended that the rate of institutionalization of the elderly must be closely monitored. The demand for personal care home services can be reduced by targeting new resources at supported independence and supporting caring families.

DISPOSITION: Refer to the Manitoba Health Services Commission to conduct a survey of personal care homes residents like the Adult Medical Patient Study
(Also related to Improvement in Current Services, Service, and, Policy Review and Development, Service Utilization Review)

The Sub-Committee on Services for the Elderly recommended that the current geriatric day hospital capacity in Winnipeg is sufficient. Should a reduction in the present capacity occur, this must be paralleled by concurrent development of alternative, more appropriate and less expensive programs (e.g. - generic and specialized Adult Day Care).

DISPOSITION: Supported by the Health Services Review Committee
(Also related to Information Required, Mechanisms Developed/Instituted to Monitor Information, and Endorsement of Present Policy/Practice)

The Sub-Committee on Services for the Elderly recommended that Manitoba Health continue its commitment to provide leadership and funding for the development of basic community support services to sustain and enhance the health of the "well elderly" in order to offset the premature entry of persons into the health care system.

DISPOSITION: Refer to Manitoba Health
(Also related to Improvement in Current Services, Service)

The Emergency Health Care Sub-Committee recommended that hospitals larger than 60 beds should have 24 hour in-hospital physician coverage in the emergency room. An operational method of in-patient admission should be developed to reduce pressures upon emergency rooms.

DISPOSITION: Refer to the Manitoba Health Services Commission, Facilities Division
(Also related to Improvement in Current Services, Manpower)

The Emergency Health Care Sub-Committee recommended that each hospital should have an active bed utilization committee responsible for admission and discharge planning.

DISPOSITION: Refer to the Sub-Committee on Administrative Impacts

The Emergency Sub-Committee recommended that alternative forms of community health care for the elderly should be examined to reduce demand upon acute care beds.

DISPOSITION: Supported by the Health Services Review Committee within funding limits of the $17.5M (see Volume I, page 14)

The Obstetric Sub-Committee recommended that hospital or departmental admission and discharge committees should actively monitor the indications for admission to acute care beds as well as length of stay, and should implement admission and discharge policies with cross-institutional comparisons. This activity should be the responsibility of the medical staff association at each hospital.

DISPOSITION: Refer to the Sub-Committee on Administrative Impacts

(Also related to Improvement in Current Services, Service, and Policy Review and Development, Service Utilization Review)

The Obstetric Sub-Committee recommended that the community-based high-risk antepartum home care program currently operating at St. Boniface General Hospital (offering formal visiting and monitoring by appropriately trained R.N.'s in the home) should be further developed to cover a range of antepartum problems.

DISPOSITION: Supported by the Health Services Review Committee and refer to the Manitoba Health Services Commission and Manitoba Health.

The Obstetric Sub-Committee recommended that postpartum early discharge programs modelled on the pilot project at St. Boniface General Hospital should be set up to serve the whole of Winnipeg and eventually the whole province. Although the program may not be required or desired by all, it should be available to all patients, who should be screened as to their needs on admission to the unit and reassessed prior to discharge.

DISPOSITION: Supported by the Health Services Review Committee and refer to Manitoba Health Services Commission and Manitoba Health

The Obstetric Sub-Committee recommended that an adequate nursing education program should be provided in the hospital prior to discharge and a public health nurse follow-up program should be developed to provide home visits for selected post operative early discharge patients.

DISPOSITION: Supported by the Health Services Review Committee and refer to the Manitoba Health Services Commission and Manitoba Health (Also related to Improvement in Current Services, Service)

III. System Reorganization

III. A) Consolidation of Services

The Cardiovascular Disorders Sub-Committee recommended that all major diagnostic and therapeutic facilities for congenital heart problems should be updated and expanded, preferably in one major tertiary care institution which at the present time is at Children's Hospital, Health Sciences Centre.

DISPOSITION: Refer to the Provincial Cardiac Advisory Committee
(Also related to Improvement in Current Services, Diagnostic and Treatment Equipment)

The Sub-Committee on Services for the Elderly recommended that government proceed expeditiously to consolidate the planning, resource priority setting and allocation of existing and future services for the elderly under one department of government.

DISPOSITION: Refer to the Provincial Gerontologist for presentation to the Minsiter

The Obstetric Sub-Committee recommended that government and the hospitals should adopt, as a long-term goal, the ideal of two obstetric units to serve the City of Winnipeg, each with separate low-risk and high-risk areas but all under one roof and on one floor.

DISPOSITION: Refer to the Manitoba Health Services Commission

The Oncology Sub-Committee recommended that all children with cancer be treated out of one centre with access to the facility and its resources being available to all pediatric oncologists.

DISPOSITION: Refer to the Manitoba Cancer Treatment and Research Foundation, and the Manitoba Health Services Commission

The Pediatric Sub-Committee recommended that pediatric admissions in the urban area should be limited to the Children's Centre and St. Boniface General Hospital.

DISPOSITION: The Health Services Review Committee agrees in principle with consolidation

The Pediatric Sub-Committee recommended that there should be only one pediatric intensive care unit in Manitoba located at the Children's Centre.

DISPOSITION: Supported by the Health Services Review Committee

III. B) Regionalization of Services

The Cardiovascular Sub-Committee recommended that with an increase in the aging population sector there will be a corresponding increased demand for pacemaker services. Smaller units of less than 20-30 implantations per year should be amalgamated with larger units wherever geographically feasible, and adequate facilities for follow-up and assessment should be maintained. The present pacemaker caseload in the province is slightly over 350 patients per year. Attempts should be made to do some pacemaker implants on an NFA basis but the operating room suites in these areas and the supportive services should be at par with those in the main operating room in the hospitals. This will potentially reduce the hospitalization costs of these patients.

DISPOSITION: Supported by the Health Services Review Committee
(Also related to Communication, Professional)

The Sub-Committee on Services for the Elderly recommended that hospital-based services with a focus on services to the elderly, should be regionally available throughout Winnipeg and in rural Manitoba. Such programming may occur within Extended Treatment Units, Geriatric Assessment Units or Departments of Geriatric Medicine, and should have clinical direction from Geriatricians, either within the same facility or easy commutable distance. Links and backup resources between Winnipeg and both rural and northern communities must be established.

DISPOSITION: Supported by the Health Services Review Committee and refer to the Manitoba Health Services Commission

The Gastrointestinal Sub-Committee recommended that endoscopy facilities and skilled endoscopists must be available in "regional" centres.

DISPOSITION: Refer to the Manitoba Health Services Commission, Facilities Division
(Also related to Improvement in Service)

The Gastrointestinal Diseases Sub-Committee recommended that the government should investigate the value of developing "mini regions" where concentration of new sophisticated diagnostic and therapeutic modalities should improve health care while preventing costly duplication of facilities.

DISPOSITION: Refer to the Sub-Committee on Administrative Impacts

The Gastrointestinal Diseases Sub-Committee recommended that regionalization of more sophisticated radiology and skilled fiberoptic endoscopists are necessary to improve the efficiency of making the diagnosis of these diseases.

DISPOSITION: Refer to the Sub-Committee on Administrative Impacts

The Indian Health Care Sub-Committee recommended that Manitoba, Canada, and Indian organizations jointly set up a mechanism for the transfer of health services delivery to local control.

DISPOSITION: Recommend that the Deputy Minister convene a meeting of the three parties
(Also related to System Reorganization, Planning, and Policy Review and Development, Standards, Criteria, Evaluation Guidelines)

The Obstetric Sub-Committee recommended that free access to out-patient perinatal assessment facilities must be made available to patients throughout the province by providing further development of the antepartum outreach program utilizing visitation by R.N.'s and obstetricians to selected rural areas. A study done in the Island Lake area demonstrates cost effectiveness of this program.

DISPOSITION: Refer to the Manitoba Health Services Commission, the Health Sciences Centre, St. Boniface General Hospital, and the Director of Maternal and Child Health

The Obstetric Sub-Committee recommended that in all cases where early discharge identification of patients at increased fetal or neonatal risk is possible, these patients should be transferred to a high-risk centre for delivery.

DISPOSITION: Refer to the Health Sciences Centre, St. Boniface General Hospital, and the College of Physicians and Surgeons of Manitoba

III. C) Provincial Programs

The Cardiovascular Disorders Sub-Committee recommended that pediatric cardiology specialists should provide consulting services to communities outside of Winnipeg and that a mechanism for this should be developed by arrangements between the Department of Pediatrics and Child Health Care and the practicing rural physician.

DISPOSITION: Refer to the new Pediatric Provincial Committee

The Obstetric Sub-Committee recommended that the Manitoba Health Services Commission again review the proposed Manitoba perinatal education program as a matter of priority. This should be done with a view to using this as a mechanism to improve obstetric and neonatal care in the rural areas and to facilitate desirable trends such as consolidation and regionalization as a voluntary, evolutionary process. This program should be part of an overall provincial perinatal program.

DISPOSITION: Refer to the Manitoba Health Services Commission, the Maternal and Child Health Directorate, the University of Manitoba, the Health Sciences Centre, and St. Boniface General Hospital
(Also related to System Reorganization, Regionalization of Services)

The Obstetric Sub-Committee recommended that the Manitoba Health Services Commission should again review the proposed Manitoba perinatal education program as a matter of priority, recognizing this to be a mechanism for improving the standards and cost effectiveness of obstetric and neonatal care in rural and urban areas. This program should be part of an overall provincial perinatal program and should include both physicians and nurses.

DISPOSITION: Refer to the Manitoba Health Services Commission, the Maternal and Child Health Directorate, the University of Manitoba, the Health Sciences Centre, and St. Boniface General Hospital
(Also related to Policy Review and Development, Standards, Criteria, Evaluation Guidelines)

The Oncology Sub-Committee recommended that pediatric oncology should be developed as a provincial program.

DISPOSITION: Refer to the new Pediatric Provincial Committee

The Oncology Sub-Committee recommended that an expansion of the Outreach Program should include urban hospitals and additional rural centres.

DISPOSITION: Supported in principle by the Health Services Review Committee

The Pediatric Sub-Committee recommended that a comprehensive provincial pediatric rehabilitation program should be developed in conjunction with the Children's Centre and the Rehabilitation Centre for Adults. The existing Rehabilitation Centre for Children should be closed.

DISPOSITION: Refer to the Provincial Pediatric Review Committee
(Also related to Phase-Out/Close)

III. D) Planning

The Continuing Care Sub-Committee recommended that a Conjoint Planning Committee (a standing committee) be established to: (a) insure integrated planning of community and institutional sectors; (b) review and assess proposals for developing services; and (c) monitor and review programs. The Conjoint Planning Committee should be composed of representatives of: the Office of Continuing Care, the Manitoba Health Services Commission, one representative from the hospital sector, one representative from the personal home care sector, and one representative from the community (appointed by the Minister of Health). This committee will report to the Minister of Health or as the Minister directs. Any recommendation from the committee for expansion or for new programs requires the Minister's approval for funding and appropriation of funds.

DISPOSITION: The Health Services Review Committee recommended that a Conjoint Planning Committee should be appointed.

The Continuing Care Sub-Committee recommended that in order to maintain the cost effectiveness of the Continuing Care Program, to avoid fragmentation, and to provide the best service to individuals, any new program, existing program or pilot project must be integrated into the Continuing Care Program and planned conjointly.

DISPOSITION: Supported by the Health Services Review Committee within funding limits of the $17.5M (see Volume I, page 14)
(Also related to Policy Review and Development, Standards, Criteria, Evaluation Guidelines)

The Continuing Care Sub-Committee recommended that the Manitoba Health Services Commission, the Office of Continuing Care, the Departments of Housing and Community Services, and organizations of the handicapped develop a long-range plan for handicapped persons.

DISPOSITION: The Health Services Review Committee concurs that a plan be developed

The Sub-Committee on Services to the Elderly recommended that Manitoba Housing and the Canadian Mortgage and Housing Corporation should adopt a proactive planning and resource allocation approach. Such planning should include consultation with the Manitoba Health Services Commission and Manitoba Health Regional Offices.

DISPOSITION: Refer to the Deputy Minister for consideration

The Indian Health Care Sub-Committee recommended that prior to transfer of health services delivery to local control, senior administrator levels of both governments and Indian organizations should work on interim measures for cooperation.

DISPOSITION: Refer to the Deputy Minister

The Indian Health Care Sub-Committee recommended that a tripartite committee should be established to make recommendations and decisions at senior levels to deal with health and health-related matters of Indian communities.

DISPOSITION: The Health Services Review Committee concurs that a Tripartite Committee should be established

The Indian Health Care Sub-Committee recommended that joint endeavors such as common environmental services, shared training and orientation programs for health personnel and health demonstration projects should be considered for implementation.

DISPOSITION: Refer to the Tripartite Committee
(Also related to Demonstration Projects,
Service, and Demonstration Projects,
Education)

The Indian Health Care Sub-Committee recommended that Indian and Inuit should be involved with the provincial and federal governments in setting priorities for Native health related training programs.

DISPOSITION: Refer to the Tripartite Committee

The Indian Health Care Sub-Committee recommended that a planning process should be developed to direct the ongoing development, coordination and operation of health services in rural and northern areas as it impacts on populations at special risk (ie., Indians and elderly populations).

DISPOSITION: Refer to the Tripartite Committee

The Indian Health Care Sub-Committee recommended that specific topics such as meningitis, otitis media, dental caries and mental health should be identified as priorities for improved intervention.

DISPOSITION: Refer to the Tripartite Committee

The Obstetric Sub-Committee recommended that the present plethora of committees surrounding perinatology should be reviewed and the specific mandate and terms of reference of each committee must be defined. It is proposed that one steering committee be established to oversee a provincial perinatal program with subcommittees to handle specific tasks, eg. - professional education, patient education, liaison between tertiary care hospitals, neonatal transport, etc. The chairman of these sub-committees would sit on the steering committee. The chairman, or co-chairman (obstetrics and neonatology) of the steering committee may either have a role in directing the provincial perinatology program, or may function as advisor and committee spokesman on reproductive health care to government and the Manitoba Health Services Commission.

DISPOSITION: Refer to the Director of Maternal and Child Health

The Out-Patients Sub-Committee recommended that the knowledge, technical expertise and practical experience gained from the four model out-patient departments should then be used to plan and develop as required additional out-patient facilities and services throughout the province.

DISPOSITION: Supported by the Health Services Review Committee within funding limits of the $17.5M (see Volume I, page 14)
(Also related to Policy Review and Development, Standards, Criteria, Evaluation Guidelines)

The Pediatric Sub-Committee recommended that new ambulatory programs should be developed in areas of demonstrated need which would provide an alternative to in-patient services. Coordination between Manitoba Health and Manitoba Education should include consideration for joint funding.

DISPOSITION: Supported by the Health Services Review Committee within funding limits of the $17.5M (see Volume I, page 14)

III. E) Administrative Impacts

The Continuing Care Sub-Committee recommended that as a hospital approaches a maximum number of in-transit patients, it can be assured that the Continuing Care Program will continue to give high priority attention to transferring a person to a nursing home as quickly as possible, to the extent that the number of personal care home vacancies are a match with patient needs.

DISPOSITION: Refer to the Deputy Minister
(Also related to Policy Review and Development, Standards, Criteria, Evaluation Guidelines)

The Continuing Care Sub-Committee recommended that some means be sought/established to ensure flexibility to the recruitment of service providers in those classes affected by staff year status.

DISPOSITION: The Health Services Review Committee recommends global funding to ensure flexibility

The Continuing Care Sub-Committee recommended that administrative supports necessary to sustain management, planning and delivery be made available from centralized departmental administrative services or be established within the Office of Continuing Care.

DISPOSITION: Refer to the Deputy Minister

The Continuing Care Sub-Committee recommended that to maximize service limits, a system be developed for responding to a breakdown in provision of care at home, through emergency access to hospital.

DISPOSITION: Supported by the Health Services Review Committee within funding limits of the $17.5M (see Volume I, page 14)
(Also related to Policy Review and Development, Standards, Criteria, Evaluation Guidelines)

The Sub-Committee on Services for the Elderly recommended that considering the legitimate health needs of an aging society and their utilization of hospital services, it is recommended that all hospitals develop specific strategies to improve their own clinical resources for elderly patients and include mechanisms for linkage with appropriate community resources.

DISPOSITION: Refer to the Sub-Committee on Administrative Impacts

The Sub-Committee on Services for the Elderly recommended that a protocol should be developed for the transfer of social crisis admissions from hospitals to more appropriate locations, e.g. - personal care homes or residential care facilities.

DISPOSITION: Refer to the Sub-Committee on Administrative Impacts
(Also related to Policy Review and Development, Standards, Criteria, Evaluation Guidelines)

The Obstetric Sub-Committee recommended that the Manitoba Perinatal Education Program should make use of time saving and cost effective teaching methods such as teleconferencing, video cassette library and incorporation of perinatal education in meetings of the College and Physicians and Surgeons and of the Manitoba Medical Association.

DISPOSITION: Refer to the Sub-Committee on Administrative Impacts

The Oncology Sub-Committee recommended that the Manitoba Cancer Treatment and Research Foundation maintain an interest in the screening for other malignancies should cost effective procedures become available.

DISPOSITION: Refer to the Sub-Committee on Administrative Impacts

The Out-Patients Sub-Committee recommended that out-patient departments insure effective and efficient coordination of patient care services within the out-patient clinics.

DISPOSITION: Refer to the Sub-Committee on Administrative Impacts

The Out-Patients Sub-Committee recommended that to promote greater efficiency and more effective use of resources, out-patient departments should be established as a separate administrative division or section within the parent hospitals. The single administrative structure must include direct involvement from the health care professionals working in the area.

DISPOSITION: Refer to the Sub-Committee on Administrative Impacts
(Also related to System Reorganization, Planning)

III. F) Funding

The Continuing Care Sub-Committee recommended that budgeting for Continuing Care must accommodate discretionary funds for unforeseen new programs or expenses that are approved by the Conjoint Planning Committee which could not have been estimated within normal growth mechanisms.

DISPOSITION: Refer to the Deputy Minister

The Sub-Committee on Services for the Elderly recommended that physician fee tariffs should be adjusted to recognize necessary medical services for the elderly that are uniquely different and more time consuming from the rest of the adult population.

DISPOSITION: Refer to the Manitoba Health Services Commission and the Manitoba Medical Association for discussion
(Also related to Improvement in Current Services, Service)

The Sub-Committee on Services for the Elderly recommended that the Manitoba Health Services Commission and the Office of Continuing Care continue their joint planning to ensure that hospital facility backup is available to support heavier care in the community. Both hospital and community care programs must recognize their mutual resource dependency. However, joint planning is ineffective unless the funding parameters support this planning.

DISPOSITION: Refer to the Sub-Committee on Administrative Impacts
(Also related to System Reorganization, Planning)

The Gastrointestinal Sub-Committee recommended that a fee schedule must be developed to allow payment for interventional procedures carried out with the use of ultrasound (eg. - biopsy, drainage, etc.).
DISPOSITION: Refer to the Manitoba Health Services Commission, Insurance Division

The Indian Health Care Sub-Committee recommended that funding agencies should be asked to identify specific funds available for research related to Indian health care and involve Indians in the allocation of these funds.
DISPOSITION: Refer to research funding agencies

The Not-For-Admission Surgery Sub-Committee recommended that incentives to expand out-patient surgery are required to alter physicians' patterns of practice, achieve some cost savings, and provide reduced waiting periods for patients.
DISPOSITION: Refer to the Manitoba Health Services Commission and the Manitoba Medical Association for discussion

The Not-For-Admission Surgery Sub-Committee recommended that payment procedures which discourage use of local anesthesia should be reviewed.
DISPOSITION: Refer to the Manitoba Health Services Commission and the Manitoba Medical Association for discussion

The Obstetric Sub-Committee recommended that the proposed Manitoba perinatal education program should be properly funded with an adequate sessional fee to compensate physicians (university or private practice) for time lost in practice when involved in education activities and a salary for two or three core people with protected time to adequately plan, coordinate and deliver such education.
DISPOSITION: Refer to the Manitoba Health Services Commission and the Manitoba Medical Association for discussion

The Out-Patients Sub-Committee recommended that out-patient departments should be assigned separate budgets and be held accountable for those budgets.
DISPOSITION: Refer to the Manitoba Health Services Commission, Facilities Division

The Out-Patients Sub-Committee recommended that new cost sharing arrangements should be established for out-patient departments in teaching hospitals. Negotiations must include representatives from the teaching hospitals, the Faculty of Medicine, the Manitoba Health Services Commission and the geographical full-time physicans.
DISPOSITION: Refer to the Manitoba Health Services Commission and other parties for discussion

The Out-Patients Sub-Committee recommended that educational costs should be identified as a separate item in the budgets or out-patient departments. Cost-sharing arrangements for educational activities should be determined separately through negotiations involving the teaching hospitals, the educational programs which use the out-patient facilities, and representatives from the provincial government.
DISPOSITION: Refer to the Minister of Health and the Minister of Education for resolution

The Pediatric Sub-Committee recommended that the Manitoba Health Services Commission should develop methods for funding hospitals that encourage ambulatory care of patients.

DISPOSITION: Refer to the Manitoba Health Services Commission, Facilities Division

The Pediatric Sub-Committee recommended that ambulatory care programs should be funded on a programmatic basis recognizing that they extend to a wide area in the community and cross jurisdiction lines.

DISPOSITION: Refer to the Deputy Minister

The Respiratory Disorders Sub-Committee recommended that global budgeting practices for hospitals should be changed to provide incentives for hospital funding analogous to the diagnostic related grouping utilized in the United States' hospitals.

DISPOSITION: Refer to the Sub-Committee on Administrative Impacts

IV. Communication

IV. A) Professional

The Cardiovascular Disorders Sub-Committee recommended that the practicing rural physicians and the public at large should be properly informed about availability of these services through traditionally recognized professional means of information.

DISPOSITION: Refer to the Manitoba Health Services Commission and the Manitoba Medical Association

The Cardiovascular Disorders Sub-Committee recommended that the rural facilities for initial primary care of acute cardiac events seem to be adequate at the present time but more liaison is needed between the sub-committee dealing with acute care problems and transportation of critically ill patients to assure a proper referral pattern to tertiary care centres.

DISPOSITION: Refer to the Manitoba Health Services Commission (Also related to Policy Review and Development, Standards, Criteria, Evaluation Guidelines)

The Continuing Care Sub-Committee recommended that hospitals recognize persons in-transit to nursing homes as legitimate occupiers of acute beds and that positive and appropriate attitudes be promoted towards these persons among both physicians and staff, and specifically, that the use of the term "bed-blocker" be actively discouraged.

DISPOSITION: Refer to the Manitoba Health Services Commission, Long-Term Care program

The Continuing Care Sub-Committee recommended that in the event that a hospital is experiencing or expects to experience a special problem in this regard, it contact the Continuing Care Program as soon as possible to resolve the problem.
DISPOSITION: Refer to hospitals

The Obstetric Sub-Committee recommended that concerning professional education, there must be a coordinated approach to continuing professional education of physicians and nurses to ensure high standards of patient care and to encourage efficient utilization of services and resources within the context of a provincial perinatology program. Financial resources must be identified to support such a continuing professional education program.
DISPOSITION: Refer to the University of Manitoba

The Obstetric Sub-Committee recommended that physicians (obstetricians, family physicians and pediatricians) must be educated on the safety and advantages of early discharge as part of a coordinated professional education program.
DISPOSITION: Refer to the University of Manitoba

IV. B) Public Education

The Emergency Sub-Committee recommended that health promotion measures should be encouraged such as education regarding alcohol and safe driving as well as CPR methods for the lay public.
DISPOSITION: Refer to Manitoba Health

The Gastrointestinal Diseases Sub-Committee recommended that physicians should make the population aware of the possible benefit of diet and should institute widespread use of stool occult blood testing as a screening test for gastrointestinal neoplasms.
DISPOSITION: Refer to Manitoba Health

The Indian Health Care Sub-Committee recommended that the Indian Health Care Sub-Committee Report should be made a public document.
DISPOSITION: Refer to the Minister of Health
(Also related to Communication, Professional)

The Indian Health Care Sub-Committee recommended that the statistics of a health information system should be made available in a public document on an annual basis.
DISPOSITION: Refer to the Manitoba Health Services Commission

The Obstetric Sub-Committee recommended that concerning patient education for high-risk antepartum patients who are to be followed in the home or hostel environment, provision must be made for detailed patient education in the most efficient fashion, perhaps with the assistance of nurse educators and a comprehensive series of video tapes.
DISPOSITION: Refer to the Sub-Committee on Administrative Impacts

The Obstetric Sub-Committee recommended that a system of standardized perinatal patient education must be set up in the province.

DISPOSITION: Refer to the University of Manitoba

The Oncology Sub-Committee recommended that the Manitoba Cancer Treatment and Research Foundation and the province should increase their involvement in the monitoring of potential carcinogens in the workplace and in the environment and should both play a larger role in public education.

DISPOSITION: Refer to the Manitoba Cancer Treatment and Research Foundation and Workplace Safety Committees

The Pediatric Sub-Committee recommended that both health professionals and the public should be made aware of the cost of the present health care system and an assessment of the public education program's effect on utilization of the health care system should be made.

DISPOSITION: Refer to the Manitoba Health Services Commission, Manitoba Association of Registered Nurses, and the Manitoba Medical Association
(Also related to Communication, Professional)

The Respiratory Sub-Committee recommended that effective anti-smoking advertising should be undertaken.

DISPOSITION: Refer to Manitoba Health

V. Information Required

V. A) Issue to be Studied

The Cardiovascular Disorders Sub-Committee recommended that since with time an increased number of elderly benefit from newer developments in cardiac therapeutics, both medical and surgical, no patient should be denied the treatment on the basis of age alone.
DISPOSITION: Supported by the Health Services Review Committee

The Continuing Care Sub-Committee recommended that the issue of emergency hospital use and triage at home be referred to the Conjoint Planning Committee to assess the size of the target group and identify those already on home care, and determine whether the Continuing Care program should be provided with resources to make intake, nursing and homemaking services available on a 24-hour-a-day basis to respond to referrals from hospital emergency wards.
DISPOSITION: Refer to the Sub-Committee on Administrative Impacts

The Continuing Care Sub-Committee recommended that a review of needs of the North be made, involving the Office of Continuing Care, the Manitoba Health Services Commission, and the Northern Medical Unit.
DISPOSITION: Refer to three offices listed

The Continuing Care Sub-Committee recommended that the Conjoint Planning Committee review the need for self-care supplies and the impact on Home Care and the total care system, with a view to recommending appropriate action.
DISPOSITION: Refer to the new Conjoint Planning Committee

The Sub-Committee on Services for the Elderly recommended that the Province of Manitoba should establish a Working Group to study the range of housing options that are required to develop a housing continuum. The Working Group should include representatives from Manitoba Health, Housing and Community Services.

DISPOSITION: Recommend to the three Ministers that a working group be established

The Indian Health Care Sub-Committee recommended that a survey of the Native population in Manitoba's urban centres should be undertaken to determine the impact of migration upon health care utilization.

DISPOSITION: Refer to the Winnipeg Social Planning Council

The Not-For-Admission Surgery Sub-Committee recommended that a formal study of booking procedures, comparing block booking with other methods in Winnipeg hospitals should be undertaken.

DISPOSITION: Refer to the Winnipeg hospitals for study

The Oncology Sub-Committee recommended that a serious feasibility study for a combined pediatric/adult marrow transplant program be undertaken immediately.

DISPOSITION: Refer to the Manitoba Cancer Treatment and Research Foundation, and the Manitoba Health Services Commission

The Oncology Sub-Committee recommended that there be a careful re-examination of the current method of delivery of social work services to cancer patients throughout the province, for the purpose of augmenting and improving coordination of services.

DISPOSITION: Refer to the Manitoba Cancer Treatment and Research Foundation and to the Manitoba Health Services Commission
(Also related to System Reorganization, Planning)

The Out-Patients Sub-Committee recommended that Manitoba Health should make a comparison of the costs accrued to the provincial health care budget by alternative types of health service delivery and recommend the most cost effective combination.

DISPOSITION: Refer to the Sub-Committee on Administrative Impacts
(Also related to Policy Review and Development, Standards, Criteria, Evaluation Guidelines)

The Pediatric Sub-Committee recommended that further research on the causes and prevention of respiratory disease in infants and children is needed and should be fostered by the province.

DISPOSITION: Refer to the University of Manitoba

The Pediatric Sub-Committee recommended that the financing of rehabilitation programs for children should be reviewed and adequate resources should be appropriated.

DISPOSITION: Refer to the Manitoba Health Services Commission, Facilities Division

The Pediatric Sub-Committee recommended that a further study of rural pediatric beds should be undertaken.

DISPOSITION: Refer to the Manitoba Health Services
Commission and University of Manitoba

V. B) Mechanisms Developed/Instituted to Monitor Information

The Cardiovascular Disorders Sub-Committee recommended that there is a need for better reporting of major cardiac events affecting adult population which should comply with accepted nomenclature of the diseases. This information, when properly assembled, should be of value in the planning of future needs for facilities, resources and manpower. This deficiency should be easy to adjust.

DISPOSITION: Refer to the Manitoba Health Services Commission and University of Manitoba

The Cardiovascular Disorders Sub-Committee recommended that since there is a significant reduction in the mortality rate from coronary artery disease and allied problems on this continent over the past 25 years, sound and aggressive public educational measures should be implemented for all ages starting at school levels relative to prevention of atherosclerosis and coronary artery disease.

DISPOSITION: Refer to the University of Manitoba and the Department of Education

The Sub-Committee on Services for the Elderly recommended that personal care home admission criteria and the panel process must be examined regularly, and audit procedures should be developed and instituted.

DISPOSITION: Refer to the Sub-Committee on Administrative Impacts

The Gastrointestinal Diseases Sub-Committee recommended that the Manitoba Health Services Commission should consult with skilled epidemiologists/computer experts to develop its data reporting capability to allow "medical" interpretation of the potentially important information being collected and computerized.
DISPOSITION: Refer to the Manitoba Health Services
Commission

The Indian Health Care Sub-Committee recommended that an improved information system should be developed to ensure that accurate, timely and complete health status and health care data are available by age, sex, residence, community and region, cross indexed to relevant indicators.
DISPOSITION: Refer to the Manitoba Health Services
Commission, Insurance Division

The Not-For-Admission Surgery Sub-Committee recommended that the Manitoba Health Services Commission information gathering methods should be altered to provide the capability of measuring accurately and uniformly, hospital by hospital, the division of surgery into in-patient and day surgery procedures.
DISPOSITION: Refer to the Manitoba Health Services
Commission, Insurance Division

The Obstetric Sub-Committee recommended that the existing mechanism for the identification of the high-risk infant in the neonatal period should be expanded and implemented at both tertiary care institutions with a system of formal communication of information to the physician and public health nurse in the community.
DISPOSITION: Refer to the Health Sciences Centre and the
St. Boniface General Hospital

The Obstetric Sub-Committee recommended that a follow-up program must be available for evaluation of neurodevelopmental outcome of high-risk infants discharged from both neonatal intensive care units to assess provincially the efficacy of intervention and therapy in the antepartum, intrapartum and neonatal periods.

DISPOSITION: Refer to the Manitoba Health Services Commission, the Health Sciences Centre, and St. Boniface General Hospital
(Also related to Improvement in Current Services, Service)

The Oncology Sub-Committee recommended that the Radiation Protection Service which is a joint function of Manitoba Environment and Workplace Safety and Health and the Manitoba Cancer Treatment and Research Foundation should be maintained and consideration given to further expansion in areas of non-ionizing radiation.

Disposition: Refer to the three organizations
(Also related to Endorsement of Present Policy/Practise)

The Oncology Sub-Committee recommended that there be a development of a microcomputer based cancer patient management system for the province.

DISPOSITION: Refer to the Manitoba Health Services Commission, the Manitoba Cancer Treatment and Research Foundation, the Health Sciences Centre, and St. Boniface General Hospital

The Oncology Sub-Committee recommended that there be continued monitoring of standards of oncology nursing procedures within the province.

DISPOSITION: Refer to the Manitoba Health Services Commission, the Manitoba Cancer Treatment and Research Foundation, and the University of Manitoba

The Out-Patients Sub-Committee recommended that Manitoba Health, along with the University of Manitoba Department of Community Medicine should develop the data base necessary to make evaluation a standard part of health care planning. Improved collection and storage of specific utilization data will allow more information to be available to decision-makers.

DISPOSITION: Refer to the Manitoba Health Services Commission and the University of Manitoba (Also related to Policy Review and Development, Standards, Criteria, Evaluation Guidelines)

The Out-Patients Sub-Committee recommended that Manitoba Health, along with the University of Manitoba Department of Community Medicine should strive to develop and standardize health indicators sensitive enough to elucidate the impact of preventive and counselling services on the health status of Manitobans.

DISPOSITION: Refer to the Manitoba Health Services Commission and the University of Manitoba (Also related to Policy Review and Development, Standards, Criteria, Evaluation Guidelines)

VI. Policy Review and Development

VI. A) Standards, Criteria, Evaluation Guidelines

The Continuing Care Sub-Committee recommended that any identification of gaps and any new proposals to expand programs having components in the community be referred first to the Conjoint Planning Committee.

DISPOSITION: Supported by the Health Services Review Committee

The Continuing Care Sub-Committee recommended that any new service arising out of new treatment modalities be fully integrated into the Continuing Care Program. This should apply whether the service is initiated to be a continuing service or whether it is meant to be a demonstration, pilot or experimental project which will be evaluated before a firm decision is made about its future.

DISPOSITION: Supported by the Health Services Review Committee

The Continuing Care Sub-Committee recommended that following a vetting by the Conjoint Planning Committee, a sub-committee to review the implications of new treatment modality be established preparatory to instituting a specific change. This sub-committee, consisting of the appropriate hospital and physician personnel and staff from the Manitoba Health Services Commission and the Office of Continuing Care, would be responsible for: 1) identifying the number of persons likely to require Continuing Care services; 2) estimating the amount and types of services likely to be needed; 3) examine the costs and benefits associated with the change; 4) developing a coordinated implementation plan; 5) securing funding to ensure implementation within the current or the next fiscal year; 6) developing a framework for continuing education of professionals and providers so that they are encouraged to maximize the use of the Continuing Care Program.

DISPOSITION: Refer to the new Conjoint Planning Committee (Also related to Policy Review and Development, Service Utilization Review)

The Critical Care Sub-Committee recommended that the College of Physicians and Surgeons of Manitoba and the Manitoba Association of Registered Nurses develop appropriate qualifications criteria for both medical and nursing personnel working in intensive care areas in rural and northern areas.

DISPOSITION: Refer to the College of Physicians and Surgeons of Manitoba and the Manitoba Association of Registered Nurses.

The Sub-Committee on Services for the Elderly recommended that clear guidelines must be established to guide the use of new and existing high technology diagnostic tests. Existing tests should be reviewed and evaluated and new tests should be subject to a stringent review process before they are incorporated into routine procedures.
DISPOSITION: Refer to the Manitoba Health Services Commission and the Manitoba Medical Association

The Sub-Committee on Services for the Elderly recommended that all proposals for new programs must include a plan which evaluates the impact of the program on the patient and on the health care system. A plan for the evaluation of existing programs should be developed by all major funding and service institutions. Funding for program evaluation must be recognized as integral to funding of programs by the Manitoba Health Services Commission.
DISPOSITION: Refer to the Sub-Committee on Administrative Impacts

The Sub-Committee on Services for the Elderly recommended that guidelines which include "Quality of Life" measures must be incorporated into assessments which lead to life saving decisions, e.g. - renal dialysis and resuscitation by emergency teams in acute care hospitals. This is especially important for the "old old" or those with dementing illnesses and overwhelming diseases.
DISPOSITION: Supported by the Health Services Review Committee

The Sub-Committee on Services for the Elderly recommended that health care professionals should routinely assess and discuss relevant risk factors with clients/patients, family members and/or significant others. Furthermore, where there exists uncertainty about the potential of the individual, a trial period involving "appropriate and acceptable risk" should be permitted before decisions are made regarding long-term institutional placement.

DISPOSITION: Refer to the University of Manitoba and major hospitals
(Also related to Communication, Professional)

The Sub-Committee on Services for the Elderly recommended that the current personal care home bed planning guideline should be re-examined. Development of a new guideline should include an age and sex adjustment factor.

DISPOSITION: Refer to the Manitoba Health Services Commission, Facilities Division

The Sub-Committee on Services for the Elderly recommended that current policies and procedures for admission to a personal care home should be revised to accommodate discharge from personal care homes (application form, residential change and extended leave policy).

DISPOSITION: Refer to the Manitoba Health Services Commission, Long-Term Care Program

The Sub-Committee on Services for the Elderly recommended that the Manitoba Health Services Commission should develop and monitor a policy for geriatric day hospitals which promotes their intensive, short-term, assessment, rehabilitation and treatment capacities.

DISPOSITION: Refer to the Manitoba Health Services Commission, Facilities Division

The Sub-Committee on Services for the Elderly recommended that the Manitoba Health Services Commission should develop a policy for day hospital development in rural Manitoba. The model should address the unique needs and opportunities of rural Manitoba.

DISPOSITION: Refer to the Manitoba Health Services
Commission, Facilities Division

The Sub-Committee on Services for the Elderly recommended that all elderly persons' housing authorities and Boards be required to develop a capacity to respond to the support needs of their frailer tenants. Many of the support programs may need government funding assistance, but these could be supplemented by user fees, and local community contributions.

DISPOSITION: Refer to the Manitoba Health Services
Commission, Manitoba Health, and Manitoba
Housing
(Also related to System Reorganization,
Funding)

The Sub-Committee on Services for the Elderly recommended that such supports offered to the elderly living in seniors housing, be made available to similar persons who wish to reside in their own homes.

DISPOSITION: Refer to the Manitoba Health Services
Commission, Manitoba Health, and Manitoba
Housing

The Indian Health Care Sub-Committee recommended that the two governments should meet quickly to review, evaluate and renegotiate the memorandum of agreement of 1964 between Manitoba and Canada regarding the quid pro quo of shared services in different geographic areas of the province.

DISPOSITION: Refer to the Minister of Health

The Indian Health Care Sub-Committee recommended that Northern and isolated communities should receive uniformly good health care. The provision of uninsured services for Status Indians requires clarficiation (i.e., home care services, medical equipment, alcohol and drug treatment, personal care home eligibility, and rehabilitation for the physically disabled).

DISPOSTION: Refer to the Manitoba Health Services Commission, Manitoba Health, and the Federal Medical Services Branch

The Indian Health Care Sub-Committee recommended that both governments and the health professional licensing associations should deal with the continuing need for nurse practitioners to work in isolated locations.

DISPOSITION: Refer to both governments and professional licensing associations

The Indian Health Care Sub-Committee recommended that through the tripartite committee, Indian involvement and participation in research and evaluation activities for the Indian communities should be encouraged.

DISPOSITION: Refer to the new Tripartite Committee (Also related to Communication, Public Education)

The Indian Health Care Sub-Committee recommended that besides medical intervention methods, future Indian health planning and research should include factors of environment, education, lifestyle and sociocultural factors.

DISPOSITION: Refer to the new Tripartite Committee

The Indian Health Care Sub-Committee recommended that the professional associations, governing and licensing bodies, should be asked to develop audit and evaluation standards and systems to enable review of community, out-patient and non-facility ambulatory care and practice.

DISPOSITION: Refer to the Sub-Committee on Administrative Impacts

The Indian Health Care Sub-Committee recommended that any new program or demonstration project for Indian health care should include an evaluation component.

DISPOSITION: Supported by the Health Services Review Committee

The Obstetric Sub-Committee recommended that the essentials of postnatal care, as defined in this report, should be available to all patients on the basis of need, irrespective of social class or cultural background.

DISPOSITION: Supported by the Health Services Review Committee

The Obstetric Sub-Committee recommended that consideration should be given to reducing the cost of in-hospital postpartum care by division into two levels as follows: 1) provision of a minimum level of medical and nursing care for normal postpartum patients allowing them to recover from the physiological events of labour with emphasis on education and health promotion. The environment should be of an ambulatory nature with an emphasis on self-help, rooming-in, integrated family centered care, buffet dining, etc. Fewer nurses will be required but they should remain highly skilled in perinatal education. 2) Provision of a higher level of medical/nursing care with a more conventional nurse/patient staffing ratio for patients having complicated deliveries.

DISPOSITION: Refer to the Sub-Committee on Administrative Imacts
(Also related to Cost Effective Alternatives, Bed Reallocation)

The Obstetric Sub-Committee recommended that given proper backup services, the ideal length of stay in hospital throughout Manitoba following delivery should be as follows: Primigravida - up to 72 hours with 75% of patients being discharged in 48 hours. Multipara - 48 hours. Cesarean Section - 4 days. Complicated vaginal deliveries or cesarean section - dependent on nature of complication.

DISPOSITION: Supported by the Health Services Review Committee

The Obstetric Sub-Committee recommended that the Manitoba Health Services Commission review and accept the document "Recommended standards for maternal and newborn care" and that steps be taken to ensure that the level of care and facilities offering tertiary care service conform to these standards.

DISPOSITION: Refer to the Manitoba Health Services
Commission, Facilities Division

The Obstetric Sub-Committee recommended that steps should be taken to standardize and ensure completeness of preoperative workup for N.F.A. patients to avoid unnecessary cancellation. It is recommended that a standardized N.F.A. form or format be developed with a written instruction sheet for use throughout the province.

DISPOSITION: Refer to the Manitoba Health Services
Commission and all hospitals involved in
obstetrics

The Obstetric Sub-Committee recommended that the selection of community hospitals to continue obstetric services should be based on the criteria suggested by the committee and this must be done in consultation with an ad hoc committee representing the professions affected.

DISPOSITION: Refer to the Manitoba Health Services
Commission, Manitoba Health, and the
University of Manitoba

The Obstetric Sub-Committee recommended that the content of prenatal education classes should be standardized.

DISPOSITION: Refer to Manitoba Health

The Obstetric Sub-Committee recommended that a steering group should be established with medical and nursing representation to set up a standardized, structured and uniform approach to patient perinatal education. The group would have responsibility for setting up guidelines, for initiating, coordinating and monitoring the program, and for ensuring the provision of regular inservice and updating of prenatal class instructors in obstetrics and neonatology. This steering group might function as a sub-committee of the provincial perinatal program steering committee recommended elsewhere.

DISPOSITION: The Health Services Review Committee recommended that a steering group be established

The Out-Patients Sub-Committee recommended that as model ambulatory care facilities, out-patient departments in the teaching hospitals should be used to evaluate the impact of expanded out-patient services on both the quality and the cost of health care.

DISPOSITION: Refer to the Manitoba Health Services Commission, the Health Sciences Centre, and St. Boniface General Hosptital

The Out-Patients Sub-Committee recommended that Manitoba Health should specifically evaluate the unique problems of health care delivery to the elderly in a rural region and take these into consideration when planning provincial programs.

DISPOSITION: Refer to Manitoba Health
(Also related to Information Required, Issue to be studied)

The Pediatric Sub-Committee recommended that further assessment of the need for provincial programs which provide a regional service should be undertaken in conjunction with appropriate professional groups.

DISPOSITION: Refer to the Sub-Committee on Administrative Impacts

The Respiratory Disorders Sub-Committee recommended that personal care home admission criteria should not exclude long-term oxygen therapy. Personal care home placement for patients requiring long-term oxygen therapy is more appropriate in personal care homes than in extended care hospitals.

DISPOSITION: Refer to the Manitoba Health Services Commission, Long-Term Care Program (Also related to Cost Effective Alternatives, Bed reallocation)

The Terminally Ill Sub-Committee recommended that improvement of recognizing those patients who are terminally ill in order to offer appropriate treatment by encouraging the College of Physicians and Surgeons to develop and review standards of practice in this area.

DISPOSITION: Refer to the College of Physicians and Surgeons of Manitoba

The Terminally Ill Sub-Committee recommended that improvement of patient autonomy with regard to acceptance and refusal of treatment by encouraging the Manitoba Health Organizations, through hospital Boards, to establish practices which enhance the autonomy of patient and family.

DISPOSITION: Supported by the Health Services Review Committee (Also related to Improvement in Current Services, Service)

VI. B) Service Utilization Review

The Cardiovascular Disorders Sub-Committee recommended that information is required related to impact of referral patterns of acute cardiac problems from rural areas of Manitoba to tertiary care centres in Winnipeg, as it may affect the bed utilization in cardiac intensive care units in tertiary care institutions in Winnipeg.

DISPOSITION: Refer to the Manitoba Health Services Commission, the Health Sciences Centre, and St. Boniface General Hospital

The Continuing Care Sub-Committee recommended that the Conjoint Planning Committee consider the need for both hospital staff and qualified Continuing Care intake staff, as well as resources to be available seven days a week to handle hospital discharges.

DISPOSITION: Refer to the new Conjoint Planning Committee

The Continuing Care Sub-Committee recommended that there be a review of new and changing demand for personal care home beds to assure optimum utilization of existing facility beds and to identify priority need for any possible extension of facility resources.

DISPOSITION: Refer to the Manitoba Health Services Commission, Long-Term Care Program

The Indian Health Care Sub-Committee recommended that both the provincial Northern Patient Transportation Program and the federal Medical Services Branch Transportation Program should be reviewed and evaluated to determine whether economies might be realized.

DISPOSITION: Refer to the Manitoba Health Services Commission and the federal Medical Services Branch
(Also related to System Reorganization, Administrative Efficiencies)

The Indian Health Care Sub-Committee recommended that an examination should be undertaken of the utilization of hospital out-patient and emergency clinics by Status Indians and other Native peoples.

DISPOSITION: Refer to the Sub-Committee on Administrative Impacts

The Out-Patients Sub-Committee recommended that the Manitoba Health Services Commission should consider the type and volume of out-patient services provided as a separate criterion in establishing the global budgets for hospitals.

DISPOSITION: Refer to the Manitoba Health Services Commission, Facilities Division
(Also related to System Reorganization, Funding)

The Out-Patients Sub-Committee recommended that Manitoba Health should undertake to analyse the proportion of elderly in the province whom would require services in the forms already available (community supports, home care services, day hospitals, institutional care), and to uncover any unmet needs which may exist among the elderly in the province.

DISPOSITION: Refer to Manitoba Health

VII. Demonstration Projects

The Cardiovascular Disorders Sub-Committee recommended that based on the surgical cardiac caseload, the surgery waiting list, and the impact of frequently needed emergency or urgent surgical intervention, there should be adequate provincial facilities to accommodate treatment for at least 600-613 surgical patients per year with all ancillary services necessary to support the provision of this function.

DISPOSITION: Supported by the Health Services Review Committee within funding limits of the $17.5M (see Volume I, page 14)

The Continuing Care Sub-Committee recommended that following a positive determination by the Conjoint Planning Committee, a limited pilot project be considered in which the Continuing Care Program would employ a triage team(s) and support services to respond on a 24-hour-a-day basis to serious medical crises among home care recipients and among one specific target population in the community (e.g. - persons over age 80) by making a home visit, if necessary. Its findings would determine whether arrangements should be made for hospitalization or whether the person could be treated at home. If the decision is to manage at home, the family would be instructed as to how to deal with the situation and its care resources could be temporarily supplemented by emergency home care services until "regular" resources could be mobilized. Personal physicians would be notified as soon as possible of the action taken by the triage team.

DISPOSITION: Supported by the Health Services Review Committee within funding limits of the $17.5M (see Volume I, page 14)

The Sub-Committee on Services for the Elderly recommended that one or two regions should be selected in which the respite care program should be publicized. The effects of increased public awareness of services to support families before a crisis develops, should be monitored. If such a program results in decreased use of other institutional and medical services, then consideration should be given to advertising the program on a larger scale.

DISPOSITION: Supported by the Health Services Review
Committee within funding limits of the $17.5M
(see Volume I, page 14)

The Sub-Committee on Services for the Elderly recommended that special funding be designated to the Office of Continuing Care to undertake and evaluate a series of demonstration projects to test alternative delivery models for the provision of heavier and/or special type treatment. Included might be a model of service delivery designed to respond quickly in non-medical emergency or crisis situations, thereby preventing hospital admission.

DISPOSITION: Supported by the Health Services Review
Committee within funding limits of the $17.5M
(see Volume I, page 14)

The Out-Patients Sub-Committee recommended that model out-patient departments also should be established in at least one community hospital, and at least one rural hospital, in order to evaluate the impact of distance, travel time and coordination of services on costs.

DISPOSITION: Supported by the Health Services Review
Committee within funding limits of the $17.5M
(see Volume I, page 14)

The Out-Patients Sub-Committee recommended that the provincial health department, in conjunction with the University of Manitoba, should set up a model Community-Oriented Primary Care Program. If evaluation proves it to be successful, similar units can be established throughout Manitoba. The Health Action Centre appears to be an ideal urban setting for this model. Because problems of accessibility are particular to rural areas, a similar model should be developed in a rural region.

DISPOSITON: Supported by the Health Services Review Committee within funding limits of $17.5M (see Volume 1, page 14) (Also related to Demonstration Projects, Education)

The Out-Patients Sub-Committee recommended that within the model of the Community Oriented Primary Care Program, the problem of coordination of community health and support services and technologic investigations should receive particular attention. The problem is complex and each region may require its own solution.

DISPOSITION: Supported by the Health Services Review Committee within funding limits of $17.5M (see Volume I, page 14)

The Pediatric Sub-Committee recommended that priority should be given to the development and evaluation of innovative preventive health programs for high mortality and morbidity conditions which are potentially amenable to prevention such as trauma, drowning, burns and poisonings.

DISPOSITION: Supported by the Health Services Review Committee within funding limits of $17.5M (see Volume I, page 14)

The Pediatric Sub-Committee recommended that the Manitoba Health Services Commission and Manitoba Education should assess the need and cost effectiveness of other selected nurse practitioner programs.

DISPOSITION: Refer to the Manitoba Health Services Commission and Manitoba Education

The Terminally Ill Sub-Committee recommended that the scope of existing geriatric day hospital programs should be broadened to cover the terminally ill; begin with a pilot program at the Municipal Hospitals or St. Boniface General Hospital.

DISPOSITION: Supported by the Health Services Review Committee within funding limits of the $17.5M (see Volume I, page 14)
(Also related to Improvement in Current Services, Service)

VIII. Phase Out/Close

The Cardiovascular Disorders Sub-Committee recommended that there should be a well defined policy and mechanism for provision of implementation of new developments in cardiac sciences such as cardiac transplantation, treatment of complex cardiac rhythm disorders and others to allow proper structured utilization of these new advances in the Winnipeg region.

DISPOSITION: Refer to the Manitoba Health Services Commission and Manitoba Medical Association for discussion

The Sub-Committee on Services for the Elderly recommended that the current plan of the Manitoba Health Services Commission to phase-out, or upgrade where possible, hostel facilities is supported as a priority for implementation.

DISPOSITION: Refer to the Manitoba Health Services Commission, Facilities Division

The Obstetric Sub-Committee recommended that following completion of expansion at the tertiary care centres, consideration should be given to closure of one obstetric unit in a community hospital; the obstetric needs of the city would then be served by two combined high-risk/low-risk centres and two community hospital obstetric units.

DISPOSITION: Refer to the Manitoba Health Services Commission, Facilities Division (Also related to System Reorganization, Consolidation of Services)

IX. Endorsement of Present Policy/Practice

The Cardiovascular Disorders Sub-Committee recommended that the cardiac diagnostic ultrasound and nuclear imaging procedures should continue to function as per present arrangements.

DISPOSITION: Supported by the Health Services Review Committee

The Continuing Care Sub-Committee recommended that present cost limit and service limit policies be continued, since these are fundamental in maintaining the basic definition of Home Care (i.e., cost of appropriate care not to exceed the equivalent level of facility care).

DISPOSITION: Supported by the Health Services Review Committee

The Sub-Committee on Services for the Elderly recommended that the routine involvement of physicians on personal care home assessment panels throughout the province is supported. These physicians should be geriatricians or at least physicians with major experience/interest with the elderly.

DISPOSITION: Recommended to the Manitoba Health Services Commission, Long-Term Care Program

The Sub-Committee on Services for the Elderly recommended that the direction government is currently taking on the Support Services to Seniors policy is supported.

DISPOSITION: Supported by the Health Services Review Committee

APPENDIX A

MANITOBA

MINISTER OF HEALTH
MINISTRE DE LA SANTÉ

WINNIPEG MANITOBA
R3C 3R8

FEB 3 1984

Dear

I have requested David Pascoe, Director of the Research and Planning Directorate, to chair a Health Services Review Committee. The Review Committee will be established in February, 1984, to examine several critical health issues during the following five months. I ask that your institution participate in this important effort by appointing Mr. Gerry Hiebert.

The Review Committee will be comprised of approximately fifteen members from urban hospitals, rural hospitals, the College of Physicians and Surgeons, the University of Manitoba, the Manitoba Medical Association, the Manitoba Association of Registered Nurses, and senior government staff. The Review Committee is intended to function as a steering committee, striking sub-committees with expanded membership to review selected topics.

The terms of reference for the Review Committee are to examine current health issues and recommend future directions to the Minister of Health. Specific issues for review have not been defined for the Committee. The Committee will establish its own agenda. Examples of key topics include:

(a) hospital bed supply;
(b) ophthalmology services; and,
(c) alternatives to hospital admission.

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This listing is not intended to be exhaustive.

It is intended that members of the Review Committee meet twice per month. I have requested the Manitoba Health Services Commission to reimburse committee members for travel costs and other out-of-pocket expenses. I trust that sponsoring agencies will provide sessional fees for Review Committee members where necessary.

The suggested afternoon meeting schedule in the M.H.S.C. executive boardroom is as follows:

February 20
March 5, 19
April 2, 16
May 7, 22
June 4, 18

The secretarial/support services will be provided by the Research and Planning Directorate. If you have any questions, please contact the Chairman of the Review Committee, David Pascoe, at 772-7702; 206 - 1580 Dublin Avenue, Winnipeg, R3E 0L4.

Please notify Mr. Pascoe of your decision to participate on the Review Committee. I wish to thank you in advance for your anticipated co-operation.

Yours sincerely,

ORIGINAL SIGNED BY
L L DESJARDINS

L. L. Desjardins

APPENDIX B

ADMINISTRATIVE IMPACTS SUB-COMMITTEE

Mr. J. Litvack, Chairman
Mr. N. Kalansky
Mr. D. Krack, Recording Secretary
Mr. G. Chapman
Mr. A. Hiebert
Mr. P. Pauls

CARDIOVASCULAR SUB-COMMITTEE

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Dr. G. Collins
Dr. J. McDowell
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Dr. D. Mymin
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Mrs. H. Shortridge
Dr. H. Smith
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Ms. M. McKenzie
Ms. E. Shapiro
Dr. L. Stephen
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Dr. C. Cameron
Dr. W. Kirk, Chairman
Ms. M. McLean
Dr. J. Nefkin
Ms. P. MacDonald, Recording Secretary
Dr. P. McGarry
Dr. J. Horne

SUB-COMMITTEE ON SERVICES FOR THE ELDERLY

Ms. L. Bakken, Recording Secretary
Mr. E. Gelhorn
Mr. E. Goerz
Dr. J. Hurwitz, Chairman
Dr. J. McBeath
Dr. J. Menzies
Ms. L. Mitchell-Pedersen
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Ms. K. Thomson
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EMERGENCY HEALTH CARE SUB-COMMITTEE

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Dr. G. Bristow
Dr. G. Fuchs
Dr. B. Kirk
Dr. T. Lee, Chairman
Ms. N. Schwabe, Recording Secretary
Dr. N. Swirsky
Ms. B. Zunic

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Dr. R. Danzinger, Chairman
Mr. S. Drain, Recording Secretary
Dr. A. Elliott
Dr. G. Grahame
Dr. H. Greenberg
Dr. R. Kippen
Dr. K. McIver
Dr. W. Myers
Dr. L. Roos
Dr. C. Saunders
Dr. C. Wightman

INDIAN HEALTH CARE SUB-COMMITTEE

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Mr. W. Devine
Ms. L. Drew
Dr. B. Elliott
Mr. B. Gudmundson
Miss C. Johnson
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Dr. B. Postl, Chairman
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Dr. R. Postuma
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Dr. I. Morrison
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Dr. H. Wiens

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Dr. D. Bowman
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Dr. M. Levitt
Mrs. A. Nemecek, Recording Secretary
Ms. S. Sohar
Dr. C. Unruh

APPENDIX C

MANITOBA

MINISTER OF HEALTH
MINISTRE DE LA SANTÉ

WINNIPEG MANITOBA
R3C 3R8

JUN 14 1984

Dear

Recently, I requested several organizations[1] to participate in a review of Manitoba's health services. Representatives have been selected for this Health Services Review Committee to consider immediate issues such as cost constraint and future issues such as structures for health service delivery. The Health Services Review Committee intends to use the services of several sub-committees to investigate particular topics which require analysis and review. I appreciate your interest to participate as a sub-committee chairman.

The deliberations of the sub-committees are to take into account:

a) the maintenance of efficacious health care;

b) the acceptance of prudent fiscal restraint; and,

c) the projected increased demand for health services brought about by the anticipated increase in the number of elderly.

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[1] Manitoba Medical Association; Misericordia General Hospital; College of Physicians and Surgeons; Rural Hospital (Portage); Health Sciences Centre; Social and Preventive Medicine; University of Manitoba; St. Boniface General Hospital; Manitoba Association of Registered Nurses.

...2

Alternatives to be considered include a shift in focus from inpatient treatment to treatment on a day patient basis. This mode of treatment assumes an appropriate level of home health services to provide adequate support and/or alternative care in the patient's home. Also to be considered are current patterns of utilization of inpatient beds and the allocation of the required number of inpatient beds. Consideration will be given to the designation of certain specialty programs as provincial health care programs, with the appropriate allocation of resources to meet demonstrated patient needs. This overall review will include patient utilization in both urban and rural areas.

Given this context, I suggest that each sub-committee undertake its review within its terms of reference while taking into account the province's fiscal constraints. While government may be able to consider alternative types of services, the previous pattern of extensive service expansion will not likely re-occur in the foreseeable future. Rather than impose unilateral resource allocation, we have chosen to consult with key experts in the industry.

To focus the activities of all sub-committees, I provide the following terms of reference that are consistent with the Health Services Review Committee's mandate:

1) Each sub-committee will be requested to identify current and new categories of disease/treatment for which there is no alternative to hospitalization. Anticipating trends for the next decade for such categories may be based upon local experience and literature.

2) Each sub-committee will be requested to identify current and future categories of disease/treatment for which there are alternatives to traditional hospitalization. Recommendations for means to achieve the goal of increased out-of-hospital diagnosis/treatment will be welcomed. For each proposed change, the sub-committee will be requested to estimate the impact upon the quality of health care available in the future.

3) Although time is short, I would hope that sub-committees will be in a position to report to the Health Services Review Committee by September 30, 1984.

While the Health Services Review Committee may have suggested the names of some members for your sub-committee, please feel free to suggest additional membership that you feel appropriate (e.g. rural,

...3

physician, nursing, and other allied specialist representation). To elicit the cooperation and coordination necessary to bring together the variety of health care professionals you will have in support of the work of your sub-committee, please send your list of proposed sub-committee members to David Pascoe, Chairman of the Health Services Review Committee, 308 - 294 Portage Avenue, Winnipeg, Manitoba, R3C 0B9. Mr. Pascoe will confirm the membership of the sub-committee with the Health Services Review Committee. At least one member of the Health Services Review Committee will participate on each sub-committee to provide continuity. Professional support services to sub-committees will be provided (e.g.-minutes and data collection) by staff members of the Manitoba Health Services Commission or the Department of Health.

To begin the process, I will convene a seminar on June 19, 1984, 9:00 a.m. - 12:00 p.m., for all sub-committee chairmen to consider economic, population, and service delivery variables. Each sub-committee will be provided with information to serve its needs. Enclosed is an agenda for this seminar.

I thank you for your interest in participating in this important review process. The task before us is challenging and I am certain that the benefits that will accrue to Manitobans and the health care industry will be most rewarding. I look forward to the results of the review process.

Yours sincerely,

ORIGINAL SIGNED BY
L. L. DESJARDINS
L. L. Desjardins

Enclosure

Volume

3

REPORT OF THE HEALTH SERVICES REVIEW COMMITTEE

VOLUME III:
SUB-COMMITTEES' REPORTS

REPORT OF THE
HEALTH SERVICES REVIEW COMMITTEE

VOLUME III: SUB-COMMITTEES' REPORTS

November, 1985

Manitoba

Health

Health Services Commission
Research and Planning

308 Somerset Place
294 Portage Avenue
Winnipeg, Manitoba, CANADA
R3C 0B9

(204) 945-8599

November 15, 1985

The Honourable L. L. Desjardins
Minister of Health

Sir:

On behalf of the Committee members, I have the honour to submit the Report of the Health Services Review Committee.

Respectfully submitted,

David Pascoe
Chairman
Health Services Review Committee

ACKNOWLEDGEMENTS

The Report of the Health Services Review Committee represents thousands of hours of input from members of the fifteen sub-committees, recording secretaries and Manitoba Health Services Commission data processing staff.

The Committee joins to express its thanks to the sub-committees' recording secretaries who aided sub-committee work with formal minutes of all meetings and drafts of the sub-committee reports. The recording secretaries included the following staff:

Linda Bakken - Manitoba Health Services Commission
Sean Drain - Manitoba Health Services Commission
Donald Krack - Manitoba Health Services Commission
Phyllis MacDonald - Manitoba Health Services Commission
Ann Nemecek - Manitoba Health Services Commission
Heather Payne - Manitoba Health Services Commission
Norma Schwabe - Manitoba Health Services Commission
Linda Webster - Manitoba Health

A special thanks is extended to Lucienne Stadnyk who coordinated all Health Services Review Committee correspondence as well as revisions to the drafts of this Report.

HEALTH SERVICES REVIEW COMMITTEE MEMBERSHIP*

Lloyd C. Bartlett, M.D.	Manitoba Medical Association, Urban
Ted I. Bartman	Urban Non-Teaching Hospitals
Kenneth R. Brown, M.D.	College of Physicians and Surgeons of Manitoba
Frank J. DeCock	Manitoba Health Services Commission
William W. Devine	Rural Hospitals
Brian I. Gudmundson, Recording Secretary	Manitoba Health Services Commission and Manitoba Health
Gerry P. Hiebert**	Urban Teaching Hospitals
John M. Horne, Ph.D.	Faculty of Medicine
Nick K. Kalansky**	Urban Teaching Hospitals
Bryan W. Kirk, M.D.	Faculty of Medicine
Jack T. Litvack	Urban Teaching Hospitals
John H. McBeath, M.B.	Manitoba Health Services Commission
David W. Pascoe, Chairman	Manitoba Health Services Commission and Manitoba Health
Lawrence J. Stephen, M.D.	Manitoba Medical Association, Rural
Robyn M. Tamblyn**	Manitoba Association of Registered Nurses
John G. Wade, M.D.	Faculty of Medicine
Jack C. Wilt, M.D.**	Manitoba Health

HEALTH SERVICES REVIEW COMMITTEE FOOTNOTES

* Individual contributions do not necessarily reflect the position of the sponsoring agencies or institutions.

** Position change during the review process:

1) Gerry Hiebert resigned from the Health Sciences Centre, effective June 30, 1984, and was replaced by Nick Kalansky.

2) Nick Kalansky changed place of employment from the Health Sciences Centre to St. Boniface General Hospital, effective September 30, 1985.

3) Robyn Tamblyn changed place of employment from the Manitoba Association of Registered Nurses to St. Boniface General Hospital, effective November 7, 1984.

4) Dr. Jack Wilt retired from Manitoba Health effective September, 1985.

VOLUME III

HEALTH SERVICES REVIEW COMMITTEE

SUB-COMMITTEE REPORTS:

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- Administrative Impacts (see Volume II);
- Cardiovascular;
- Continuing Care;
- Critical Care;
- Elderly;
- Emergency;
- Gastrointestinal;
- Indian Health Services;
- Not-For-Admission Surgery;
- Obstetrics;
- Oncology;
- Out-Patient Medical Services;
- Pediatrics;
- Respiratory; and,
- Terminal Illness.

Appendix A - Minister's letter of invitation to Health Services Review Committee members

Appendix B - Membership of 15 Sub-Committees

Appendix C - Minister's letter to Sub-Committee Chairmen

PROLOGUE:

The Health Services Review Committee is aware that the Manitoba health care system is currently functioning under considerable stress. Health care facilities appear to be operating at close to capacity and there are continuing demands for services which have the potential to tax existing resources to the limit.

During many months of deliberation, the Health Services Review Committee has reviewed a considerable body of data including:

Health care utilization trends;
Population projections;
Health care funding;
Manitoba and Medicare report;
Adult Medical Patient Study; and,
Fifteen sub-committee reports.

While it was recognized that health care facilities fulfill a particular role and should be adequately resourced for that purpose, a common theme emerged to investigate viable alternatives to institutional care. All sub-committees eagerly responded to the challenge and made a genuine attempt to come to grips with the problems of increased demands upon existing fiscal and health care facility resources.

The present pressures on the system are exacerbated by a general reliance upon in-patient institutional resources. The development of the health system, since the advent of hospital insurance and Medicare, has emphasized acute care resources. Health care practitioners are often frustrated by their inability to implement viable alternatives to traditional modalities of care and cure. This reliance upon institutional resources manifests itself dramatically in the treatment and care of the elderly.

The Health Services Review Committee perceived that the province's ability to respond to health care delivery needs in Manitoba could be directed in one of several ways. These include:

1. More money for more of the same services; or,
2. Rationing of health care resources; or,
3. Develop innovative alternatives of treatment and prevention to the present emphasis on in-patient services.

The Health Services Review Committee concluded that the third option was the way to proceed. It merits support from all sections of the health care delivery system, including health providers (physicians, nurses, the Boards and administration), the public-at-large, and government. All sub-committees seriously addressed the issues and provided a number of recommendations and proposals in support of the third option, providing a cost effective continuum of accessible and appropriate health care services (ambulatory, institutional, and post-discharge supports).

The mandate from the Minister of Health to review Manitoba's health delivery network was to address innovative program ideas. All the work of the sub-committees and the Health Services Review Committee led them to concur that such emphasis is appropriate and timely for Manitoba. The recommendations from the sub-committees were considered seriously. All fifteen sub-committee chairmen are recognized leaders within their field. Thus, the review process was not an insulated, bureaucratic attempt at health care planning. Rather, it was an innovative exercise in consultation and deliberation.

To provide cost effective quality health care for Manitobans is a challenge for the entire health care system. It is proposed that the Minister continue to actively seek the assistance and counsel of the broadest constituency within the health care field in order to assure that the recommendations and proposals outlined in the Report can be translated into practical reality.

REVIEW PROCESS:

The Health Services Review Committee was formulated in December, 1983, with an invitation from the Minister of Health to individuals to participate in this ministerial review committee. This letter of invitation, which appears as Appendix A, established a framework within which Committee members were requested to participate.

The structure of the Committee was based on representation from a variety of health care segments. These included fifteen representatives from:

The College of Physicians and Surgeons of Manitoba;
Manitoba Association of Registered Nurses;
Manitoba Health;
Manitoba Health Services Commission;
Manitoba Medical Association, (Rural and Urban);
Rural Hospitals;
Faculty of Medicine, (University of Manitoba);
Urban Non-Teaching Hospitals; and,
Urban Teaching Hospitals.

This broad constituency provided a balance between institutional and organizational forces and crossed the boundaries of educational, funding, and service concerns.

The first meeting of the Health Services Review Committee was convened in February, 1984, at which time the Committee defined its work according to four broad topics. These topics were:

1) Areas which required further investigation;
2) The possible establishment of sub-committees to undertake studies on behalf of the Health Services Review Committee;
3) The process by which sub-committee reports would be received; and,
4) The form in which the Committee's work would be presented to the Minister of Health.

At subsequent meetings, the Health Services Review Committee refined its task to include four objectives. Thus, the terms of reference for the Health Services Review Committee were adopted by the Committee members and are listed as follows:

To identify major cost areas and explore consolidation;
To look for alternatives to in-patient services (e.g. - more ambulatory care);
To review current bed allocation and utilization; and,
To review criteria of hospital admissions in both urban and rural hospitals.

The Committee chose, as its vehicle of investigation, the formulation of sub-committees which were tasked to undertake specific investigations on behalf of the Health Services Review Committee. Areas of investigation were selected according to pressing issues of the day combined with those areas which presently consume a large majority of hospital days and medical services. The area of mental illness was not included under the review of the Health Services Review Committee as this had previously been reviewed with a report being tabled with the Minister of Health entitled "Mental Health Services In Manitoba, A Review and Recommendations" September, 1983.

The Health Services Review Committee thus commissioned fifteen sub-committees which reviewed the following areas:

Administrative Impacts;
Cardiovascular;
Community Health;
Critical Care;
Elderly;
Emergency;
Gastrointestinal;
Indian Health Services;
Not-For-Admission Surgery;
Obstetrics;
Oncology;
Out-Patient Medical Services;
Pediatrics;
Respiratory; and,
Terminal Illness.

During the working time of the Committee, one other review had been commissioned by the Manitoba Health Services Commission. This was a review of ophthalmology services. Although this report was not commissioned by the Health Services Review Committee, it was reviewed within the context of the overall scope of the Committee's activities.

The work of the sub-committees began with the appointment of chairmen. Chairmen were requested to prepare a membership list which required ratification by the Health Services Review Committee. In broad terms, the sub-committee's membership was constituted to balance medical input from both rural and urban practitioners, input from nursing representatives and such allied health specialists as were appropriate to the work of individual committees. Support was provided to the sub-committees by representatives of the Manitoba Health Services Commission and Manitoba Health (formerly referred to as the Department of Health). These staff members were responsible for scheduling meetings, preparing minutes, and facilitating special data runs of Manitoba Health Services Commission hospital and medical statistics. In order to provide a linkage between the Health Services Review Committee and the sub-committees, at least one member of the Health Services Review Committee was appointed as a liaison with the fifteen commissioned sub-committees. All sub-committees were supported by unique data runs of the Manitoba Health Services Commission hospital and medical statistics. Membership of the fifteen sub-committees is attached as Appendix B.

In order to provide each sub-committee chairman with an introduction to the context of the review process, a meeting was convened with the Minister of Health at which time information was presented to sub-committee chairmen. This meeting was held in June, 1984, and the letter of introduction from the Minister of Health to sub-committee chairmen is attached as Appendix C.

During the time that the Health Services Review Committee had commissioned the fifteen sub-committee reports and the tabling of these reports with the Committee, work was done to review existing information prepared by the Manitoba Health Services Commission and relevant studies which were undertaken or were currently underway at the time of the review process. The economic situation of the Province of Manitoba was presented for review by Committee members, as was general information regarding the organization of health care services in Manitoba and the trends of health service utilization and cost escalation experienced during the previous decade.

During the 1980's, the economic situation in Manitoba was less volatile than other Western Canadian provinces due to Manitoba's diversified economic base. This diversification provided Manitoba with greater resistance against the forces of recession. In 1982, Canada experienced a negative growth rate of 4.6% of the gross national product, while Manitoba experienced a negative growth rate of 2.9% of the gross domestic product. During this time unemployment in Manitoba stabilized somewhat and at the beginning of the work of the Health Services Review Committee Manitoba registered an unemployment rate of 9.4% compared to the Canadian average of 12.3%. When the Committee began its activities in February, 1984, the consumer price index for Winnipeg registered a 4.8% increase during the previous 12 months while the experience across the country was 5.5%. From June, 1981 to November, 1982, there was a net increase of 2,000 jobs registered within Manitoba. Although Manitoba fared relatively well during the period of the recession in the early 1980's, the debt of the Province of Manitoba continued to rise. The 1982 debt load for Manitoba on a per capita basis was the third highest in the country next to New Brunswick and Newfoundland. In 1982/83, 5% of the provincial budget was used to service the debt load while in 1983/84, that figure had risen to 9%.

This background information, provided for the benefit of the Health Services Review Committee, was interfaced with a Statistics Canada population study for the upcoming decade which projects a modest increase in the number of total residents in Manitoba. It is expected that between 1984 and 1995, Manitoba can expect a population increase of approximately 100,000 persons. Within this global increase, however, are three factors which were of interest to the Health Services Review Committee. The first factor included a rise in the proportion of individuals who are 65 years of age or older. By 1995 it is estimated that the elderly population will rise to 14% from 12% currently. The second factor of population change indicated a decrease of younger individuals, aged 0-14, from 22.6% to 19.8% by 1995. The third factor of population change was an anticipated decrease in the proportion of women of child bearing age as well as a slight decrease in the fertility rate.

In order to provide the members of the Health Services Review Committee with a historical review of health care utilization and expenditures, information was presented with regard to the budget of the Manitoba Health Services Commission from 1971 to 1981/82. Attention was focused on the budget of the Manitoba Health Services Commission and not on Manitoba Health because of the difficulty of attributing departmental expenditures according to programmatic commitments. The budget of the Manitoba Health Services Commission over this period of time rose at an average rate of 12.98% per year for ten years. After adjusting for inflationary trends, the budget of the Manitoba Health Services Commission grew at a real rate of 3% per year for a period of ten years. Thus, health care expenditures in Manitoba were relatively well buffered against the general trends of the recession.

REPORT OF

CARDIOVASCULAR DISORDERS SUB-COMMITTEE

OF

HEALTH SERVICES REVIEW COMMITTEE

PREPARED BY:
JAROSLAW BARWINSKY, M.D.
JULY 1985

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I. BACKGROUND

Dr. J. Barwinsky was invited by the Minister of Health's office to attend a meeting of the Health Services Review Committee on June 19, 1984 at the Holiday Inn Downtown.

This was a general meeting dealing with health care delivery in the province of Manitoba on a broad basis. Various sub-committees were organized and Dr. Barwinsky was appointed Chairman of the Cardiovascular Disorders Sub-Committee. He was then asked to submit to the Health Services Review Committee a list of names he would like to have work on the Sub-Committee with him and one that would provide a cross section of ideas and problems with health care delivery as it relates to cardiovascular problems. The following people comprise the membership of the Cardiovascular Disorders Sub-Committee; Dr. J. Barwinsky, Chairman, Dr. J. Wade, Ms. H. Payne, Dr. J. McDowell, Dr. B.A. Turabian, Mrs. H. Shortridge, Dr. N. Roos, Dr. D. Mymin, Dr. A . Miller, Dr. G. Warrian, Dr. H. Smith and Dr. G. Collins.

Three meetings were held by the Sub-Committee which produced the following report.

II. OBJECTIVES

The first priority of the Sub-committee was to focus on exactly what this Sub-committee could provide the government with in order to assist it and cover the mandate as outlined by the Honourable Larry Desjardins; "the deliberations of the sub-committees are to take into account:

a) the maintenance of efficacious health care
b) the acceptance of prudent fiscal restraint, and
c) the projected increased demand for health services brought about by the anticipated increase in the number of elderly."

Basically the purpose of the Sub-Committee is to project major trends in cardiac care over the next five to ten years.

With the above in mind the Sub-Committee decided to:

a) Document the current level of service being provided in Manitoba.
b) Identify and compare availability of facilities in urban and rural areas of Manitoba.
c) Attempt to anticipate facility and personnel requirements in five and ten years depending on changes in population.
d) Identify the number and distribution of coronary care beds in Manitoba -- are present facilities adequate.
e) Assess cardiac surgery based on age limit -- is there an age limit at which point in time one cannot justify pursuing surgical intervention and are re-do operations cost effective in terms of relief of symptoms.
f) Address the issue of reduplication of investigational procedures and the establishment of guidelines for a variety of pathological process.
g) Look at the need for non-invasive investigation -- particularly in non-teaching institutions.

While the Sub-Committee recognized the importance of the following areas it was felt that these areas are being addressed by other sub-committees:

a) Coronary Care Units.

b) Transportation of critically ill patients with cardiovascular disease.

III. METHODOLOGY

In order to meet the aims and objectives a thorough analysis was done of cardiac patient caseload over the past five years in the province of Manitoba. This period was selected in view of the fact that the science of delivery of health care to this type of patient is more or less stable at the present time. The analysis involved only services related to major diagnostic functions and surgical procedures affecting both adult patients and children with diseases of the heart and thoracic aorta. Excluded from this are such entities as hypertension which is usually managed on the ambulatory basis in office consultations and where more than often the use of tertiary care facilities are not necessary. Not considered in this submission are the requirements of peripheral vascular diseases.

The data were obtained from the Manitoba Health Services Commission registry and from Cardiology and Cardiac Surgical Services of both major hospitals - St. Boniface General Hospital and Health Sciences Centre where most of these services are delivered. The regional provincial distribution and location of service delivery for ischemic heart disease was also obtained from Manitoba Health Services Commission (Appendix 1 & 2). A five years study of cardiac valve surgery and coronary artery bypass surgery was done by Dr. J. Barwinsky for presentation for the Royal College of Physicians and Surgeons of Canada. This information was utilized for comparative purposes only to see how this service compares and contrasts with that across Canada.

The local Manitoba experience with innovative procedures such as coronary angioplasty was also considered but it was thought that with new and progressive developments in this form of treatment this item should be assessed later on and on an on-going basis.

Based on all these figures the incidence of services per 100,000 population was calculated and based on tables from Statistics Canada approximate projected estimates were made for the demand of these services for the next ten years. Not included in this consideration is progress and new developments in cardiac sciences related to cardiac transplantation which should be assessed on an annual basis.

Using information obtained from Manitoba Health Services Commission, rural resources in overall cardiac care were analysed and the efficiency of referral for tertiary care was also assessed.

IV. STATISTICAL PRESENTATION

PEDIATRIC CARDIAC CARE

Pediatric Cardiac study between 1979 and 1982 provided by the Manitoba Health Services Commission and subsequent analysis of the same problem by the Provincial Program in Cardiac Surgery during 1984 indicate that the incidence of suspected congenital heart cases is at approximately 263 per year and these will require complex consultative and diagnostic consideration. Out of that number between 91 and 95 children will require cardiac surgery of which 45 to 55 will be open heart procedures and the remaining will be so called closed heart operations. Included in that number will be approximately 20 children that will require surgery in infancy during the first year of life due to severity and complexity of the nature of their illness. Similarly other lesions could be operated on earlier in life in order to optimize the long term prognosis.

A detailed analysis of this problem was done by the Provincial Program in Cardiac Surgery and the final program for Pediatric Cardiac Surgery was submitted to the Manitoba Health Services Commission. Major diagnostic facilities are located at Children's Centre, Health Sciences Centre and some at St. Boniface General Hospital. As of 1984 all pediatric cardiac surgery is performed at Children's Centre, Health Sciences Centre, with the exception of very few ductus arteriosus ligation performed on premature infants from the nursery at St. Boniface General Hospital.

It was considered that there was a need for the specialists in pediatric cardiology to reach out to the communities in rural Manitoba to provide on site consulting services and that this could be best accomplished by the Department of Child Health Care (Department of Pediatric, University of Manitoba). This matter should be further addressed in the process of development of pediatric cardiac facilities.

ADULT CARDIAC PROBLEMS

Ischemic Heart Disease

Analysis of data from Manitoba Hospital Utilization for ischemic heart disease 1983/1984 provided by the Manitoba Health Services Commission indicates that there are approximately 6,880 cases per year of which 3,547 or 51.55% occur in Winnipeg. The same figures suggest that the incidence of acute myocardial infarctions obtained from the hospital utilization tables is approximately 33.6% or 2311.68 patients. This requires 38.9% of 91,495 hospital days allocated for the management of this problem which equals 35,577.51 hospital days (Appendix 2).

On the other hand utilizing the figures provided by the Manitoba Health Services Commission dealing with medical utilization for ischemic heart disease one finds that the total number of patients with this entity in the province is at around 37,603 of which 10.4% are diagnosed as acute myocardial infarction giving the total number of myocardial infarction of 3,910.71 patients. This consumes 16.6% of the total services devoted to this aspect which comes to 37,639.50 services in total (Appendix 1).

We did not have the opportunity to analyse the impact of this patient load on the need of intensive care facilities and other diagnostic and therapeutic resources in tertiary care institutions such as Health Sciences Centre and St. Boniface General Hospital in Winnipeg that deal with more complex and severe entitites of this issue. Hopefully this aspect will be addressed by other sub-committees.

Thus the exact number of occurance of acute myocardial infarction is difficult to define and utilizing our own statistics one can see that it could vary from 2,311.68 patients based on hospital utilization data to 3,910.71 patients based on medical utilization data.

It is obvious therefore that better methods for classification and reporting are needed for more precise planning in the future.

Analysis of the data dealing with rural resources in cardiac care which was provided by the Manitoba Health Services Commission indicates that the resources in the major rural areas are adequate to deliver primary care in acute situations. During discussion with the members of the Committee as well as using other consultations it is obvious that in case of greater urgency there is already an operational mechanism for referral patterns of these patients to major tertiary care centres in Winnipeg. The exact number of these referred patients is difficult to estimate and it is hoped that the sub-committee dealing with critical care bed problems in Winnipeg will address this issue.

Pacemaker Services

Dr. S. Kim was asked to provide a detailed analysis of the pacemaker services in Manitoba and his report addressed to the Director of the Provincial Program in Cardiac Surgery is included here without modification (Appendix 3). It was also considered that minor units dealing with the pacemaker problems and that do not have adequate pacemaker followup clinics should be amalgamated with larger centres if possible.

INVESTIGATIVE PROCEDURES

Non-Invasive

The completion of data for diagnostic ultrasound related to cardiac problems is under study now by the Provincial Program in Cardiac Surgery and this information will be available at a later date. The same is applicable to cardiological tests in nuclear medicine

Invasive Investigative Procedures

Pediatric rate for cardiovascular investigational procedure is tabulated in Appendix 4 . The calculations are based on the number of investigations done at Children's Hospital in 1984 and at St. Boniface General Hospital, plus the annual projection for the post operative follow up cases and treatment procedures for the pediatric population of ages 0 - 14 years. Based on that and utilizing Table CI - Manitoba Projected Population by Sex and Age Group (in 000's) both sexes 1983-2006 -- Manitoba Bureau of Statistics, (Appendix 5) the need for projected cases was calculated from between 1985 until 1995 as demonstrated in Appendix 6.

Adult Cardiac Investigative Procedures

The figures for adult investigative cardiovascular procedures were obtained from the Provincial Program in Cardiac Surgery for 1983 and 1984 and the total actual number includes 1,372 investigational procedures mainly coronary angiograms and cardiac catheterizations as in Appendix 7, for the population age group 15 years and over which amounts to appoximatley 165.59 procedures per 100,000 adults. Using the same source Table CI - Manitoba Project Population by Sex and Age Group (in 000's) both sexes 1983-2006 -- Manitoba Bureau of Statistics, the caseload was projected between 1985 and 1995; this is assuming that the state of art will not dramatically change between now and ten years from now.

The distribution of caseload between St. Boniface General Hospital and Health Sciences Centre was then calculated based on each institutions ability to provide this service as shown in Appendix 7 .

It was also considered that approximately 35% of non complex investigations could be done in the ambulatory care facilities in both institutions which would have a significant impact on in-hospital bed utilization and subsequent cost. Consequently it was unanimously agreed that the ambulatory care facilities should be provided for coronary angiograms and heart catheterizations in our tertiary care institutions and that these should be properly equipped and staffed.

ADULT CARDIAC SURGERY

The 1983 Manitoba adult cardiac surgical caseload was 544 cases and the total actual caseload for 1984 was 551 cases, of which 142 were valve replacements and 409 coronary bypass grafts.

Calculated on per 100,000 adult population ratio this comes to 17.33 valves per 100,000 adult patients and 50.00 per 100,000 adults for coronary bypass graft surgery or having overall total for adult open heart procedures as 67.33 per 100,000 population. This compares well with the figures from across Canada. Using this as a base and using the same source tables dealing with Manitoba population a calculated projection for adult cardiac surgical caseload has been made between 1985 and 1995 as per Appendix 6 . It should be also understood that the present waiting list is up to 6 weeks or approximately 10% to 15% of annual patients load. Thus having this in mind and considering that approximately 20% of patients may require urgent and some emergency surgery which has a significant impact on resource utilization, it is appropriate to recommend the planning of facilities for 600 - 613 cases per year with the annual fluctuation to be assessed on an on-going basis.

It was also discovered that utilizing preadmission clinics at both tertiary care institutions foreshortens the hospital stay by at least 2 days and it is also possible to establish a postdischarge follow up clinic which would significantly reduce the overall hospital stay of cardiac patients by a total of approximately 3 to 4 days. These issues should be addressed to the tertiary care institutions on an on-going basis.

NEW DEVELOPMENTS

Coronary Angioplasty

It is estimated that the total provincial caseload for these procedures will be approximately 170 cases per year. Since the present state of art on this continent in terms of indications for this procedure is slightly different from that of coronary bypass graft surgery it is difficult to predict the impact of this on total caseload for coronary bypass graft surgery but it is assumed that the impact will be minimal. This issue will be assessed on an on-going basis by the Provincial Program in Cardiac Surgery.

CARDIAC TRANSPLANTATION

With the new developments in the science of cardiac transplantation and with the better survival rate of these patients it was considered that it would be proper to recommend the establishment of regionalized units for cardiac transplantation and that there should be one in Western Canada serving the province of Saskatchewan and Manitoba, Northwestern Ontario and that Winnipeg should be a logical place for such unit. This issue should be referred for further assessment to the Provincial Program in Cardiac Surgery.

INVESTIGATION AND TREATMENT OF COMPLEX CONDUCTIVE DISTURBANCES OF THE HEART

Since the knowledge of derrangements of the electrophysiology of the heart is increasing and the treatment of the problem is available both by pharmacological and by surgical means it will be appropriate for tertiary care centres in this province, primarily those associated with the University of Manitoba, to establish both a diagnostic and therapeutic unit for this disease entity. This should be done jointly with the Departments of Cardiology and Cardiovascular and Thoracic Surgery and should be monitored by the Provincial Program in Cardiac Surgery.

REHABILITATION OF PATIENTS FOLLOWING MAJOR CARDIAC EVENTS

Attempts were made to define the role of the rehabilitation programs in recovery of patients following cardiac surgery or other major cardiac events. Based on that and the distribution of patients by region one could plan the resources in corresponding areas. Unfortunately to the date of this submission a proper report was not obtained.

RURAL RESOURCES IN CARDIAC CARE (INCLUDING BRANDON)

1. Electrocardiogram - all hospitals in Manitoba
2. Cardiac Stress Testing - Dauphin, Portage la Prairie, Flin Flon, The Pas, Brandon
3. Ambulatory E.C.G. Monitoring - Brandon, Portage la Prairie, Flin Flon
4. Echocardiography - Brandon (may also be done in an emergency in Dauphin, The Pas and Winkler)
5. Cardiovascular Nuclear Medicine - Brandon where it is limited to aneurysms and M.I. imaging
6. Ultrasonography - Brandon, Dauphin, Winkler, The Pas and approval for Steinbach
7. Cardiac Catheterization/Angiography - none
8. Coronary Care Unit - none
9. Intensive Care Unit - Brandon (12 beds), approximately 75% of the care is coronary care
10. Special Care Units - in Dauphin (3 beds), Selkirk (4 beds), Portage la Prairie (4 beds), Thompson (4 beds), Flin Flon (3 beds). Most of these beds are used for coronary care
11. Cardiac Pacemakers - Brandon

V. DISCUSSION

During almost the entire year the Committee with the help of services provided by the Manitoba Health Services Commission, Provincial Program in Cardiac Surgery, Department of Cardiology, University of Manitoba, Health Sciences Centre and St. Boniface General Hospital, Section of Pediatric Cardiology, University of Manitoba, Section of Cardiovascular and Thoracic Surgery, University of Manitoba, Health Sciences Centre and St. Boniface General Hospital had a good thorough insight into the problems related to the delivery of health care to patients with cardiac disease.

It was noted that in order to be more precise on the issue there is a need to adhere to standard nomenclature in diagnosing the cardiovascular disorders and specifically as it is related to acute cardiac events such as myocardial infarction since this would be of great value in planning of resources for the future. All members of the Committee agreed that the services should not be discontinued because of any specific age group of patients and that each patient's condition should be assessed professionally on an individual basis. In complex problems related to reoperation on coronary artery bypass graft patients or failure of the cardiac valve prosthesis it was agreed that in spite of the fact that the procedure is technically more difficult and slightly higher in terms of risks all of these individuals enjoy improvement in their symptomatic status, life style and life span.

It is possible to reduce the cost of invasive investigative cardiovascular procedures by performing them on the ambulatory care basis. It was noted that approximately 35% of elective coronary angiograms could be done on an out-patient basis. Similar consideration should be given to non complex pediatric investigations. This would significantly reduce the in-hospital stay costs. Since many pacemakers require only a short hospital stay it should be considered to do some of the pacemaker implantations on the NFA (Not For Admission) basis in major tertiary care institutions, providing that the operating room facilities in the NFA area are of the same calibre as those used in the main operating room area for that purpose. This is particularly important since the aging population will likely increase the demand for pacemaker services with considerable potential for cost increases.

The overall length of hospitalization of patients could also be reduced by structuring and organizing a proper pre-admission clinic prior to surgery where most of the necessary screening tests could be performed without any difficulties. Early discharges should be also encouraged and if needed appropriate ambulatory care facilities should be organized to see these patients early after their discharge. It is important to maintain high quality nursing in these areas, and some functions traditionally done by physicians could be done by Nurse Clinicians, as presently practiced by CVT Units at St. Boniface General Hospital and Health Sciences Centre.

Certain non-invasive diagnostic procedures could be decentralized to provide adequate access for rural residents and to improve diagnostic capabilities of rural physicians. However in sophisticative cardiac ultrasound functions there could be a shortage of properly trained technical personnel in remote areas and in view of that and for these reasons cardiac ultrasound assessment should be centralized in major tertiary care unit institutions. The same is applicable to nuclear imaging testing.

The question of need for stress testing of apparently "healthy" individuals prior to their entry into the fitness program was raised. Frequently these patients are referred to Cardiology for this type of service which frequently puts additional pressure on scarce intra-institutional resources. Consequently some of the stress testing could be regionalized or decentralized and done outside of the scope of the tertiary care institutions.

The need for an outreach pediatric cardiac services in remote areas was recognized and this subject should be addressed to the Department of Pediatrics and Child Health, specifically to Section of Cardiology of that Department for appropriate discussions and arrangements.

Although the coronary artery surgery caseload was noted to be on the decline in the United States between 1982 and 1983 the preliminary analysis of the figures between 1983 and 1984 which was presented at the meeting of the Directors of Postgraduate Training Programs in May 1985 indicates approximately 8.6% increase in the caseload over that from 1983. In Canada the surgical caseload is still on the increase by approximately 11% - 12% and this is interpreted as a "catching up phenomenon" since Canada frequently lagged behind the United States by 2 - 3 years. Since the new technology such as angioplasty and thrombolytic therapy provide short term relief, and frequently the indications for this modality differ from the same for coronary bypass graft surgery, it was considered and agreed that they will not have a significant impact on overall caseload for coronary bypass graft surgery.

It was recognized by all members of the Committee that nursing profession plays a very significant and very important role in the health care delivery to cardiac patients. Besides the regular nursing duties there is an increased demand for continuing structured and "on the job" education to keep up with new development in the field. This is well demonstrated in coronary care areas, cardiac surgical intensive care units, pacemaker programs and in special clinical units such as cardiovascular and thoracic surgical services at St. Boniface General Hospital and at Health Sciences Centre. These cardiac surgical units successfully employ nurse clinician personnel which adds quality to patients care. This program (Nurse Clinician Program) was originally developed by Nursing Department of St. Boniface General Hospital and the graduates from this Program are presently employed by both institutions - St. Boniface General Hospital and Health Sciences Centre. These individuals are able to undertake various functions of care of cardiac patients which traditionally and in the past were fulfilled by other professionals. The Committee recommended that such a program should continue to exist and that the needs for such services should be assessed on an on-going basis by the members of the nursing profession and medical staff in both tertiary care institutions. With time their functions could be expanded. The Consultative Committee of the Provincial Program in Cardiac Surgery which includes a nursing representative should be asked to monitor this phenomenon on a regular basis. With the decreasing number of postgraduate residents in training and with the increased complexity of disease that could be managed successfully these days, including severity and acuity of patients illness, involvement of these individuals, Nurse Clinicians, in patients care will have a positive impact on budgetary considerations.

Since the recent scientific medical literature clearly indicates that on the North American continent, between 1959 and 1984 there is a significant, over 25% reduction in the mortality rate from coronary artery disease and related cardiac disorders. All members of the Committee had a strong feeling that there is a need for better public education on a wide basis and at all ages starting from school age which should be directed towards prevention atherosclerotic heart disease.

VI. RECOMMENDATIONS

It is recommended that:

1. All major diagnostic and therapeutic facilities for congenital heart problems should be updated and expanded preferably in one major tertiary care institution which at the present time is at Children's Hospital Health Sciences Centre.

2. Pediatric cardiology specialists should provide consulting services to communities outside of Winnipeg and that a mechanism for this should be developed by arrangements between the Department of Pediatrics and Child Health Care and the practicing rural physician.

3. The practicing rural physicians and the public at large should be properly informed about availability of these services through traditionally recognized professional means of information.

4. Pediatric surgical cardiac caseload as generated by the population of this province will be at approximately 90 to 95 cases per year of which there will be approximately 50 - 55 open heart procedures and the remaining so called closed heart procedure.

5. There is a need for better reporting of major cardiac events affecting adult population which should comply with accepted nomenclature of the diseases. This information when properly assembled should be of value in planning of future needs for facilities, resources and manpower. This deficiency should be easy to adjust.

6. The rural facilities for initial primary care of acute cardiac events seem to be adequate at the present time but more liaison is needed between the sub-committee dealing with acute care problems and transportation of critically ill patients to assure a proper referral pattern to tertiary care centre.

7. Information is required related to impact of referral patterns of acute cardiac problems from rural areas of Manitoba to tertiary care centres in Winnipeg, as it may affect the bed utilization in cardiac intensive care units in tertiary care institutions in Winnipeg.

8. The cardiac diagnostic ultrasound and nuclear imaging procedures should continue to function as per present arrangements.

9. Analysis of invasive cardiac investigative and diagnostic problems indicates that anticipated caseload in Manitoba will be at around 1,500 - 1,600 patients per year. Since approximately 30% - 35% of these patients, with less complex procedures could be done on NFA (Not For Admission) basis proper facilities for this should be established in institutions involved in these functions. This is relevant to physical space, monitoring resources, staffing, high quality nursing and professional availability. This in itself should reduce the cost for these procedures related to hospitalization since at the present time all of them are done on in-hospital basis. It would also provide a more convenient service for the patients.

10. Based on the surgical cardiac caseload, the surgery waiting list, and the impact of frequently needed emergency or urgent surgical intervention, there should be adequate provincial facilities to accommodate treatment for at least 600 - 613 surgical patients per year with all ancillary services necessary to support the provision of this function.

11. It is estimated that there will be a need for approximately 170 coronary angioplasty per year in addition to present caseload for coronary bypass graft surgery, and since this type of therapeutic science is developing rather independently, it is considered that this may not have a significant impact on surgical caseload.

12. With an increase in aging population sector there will be a corresponding increased demand for pacemaker services. Smaller units of less than 20 - 30 implantations per year should be amalgamated with larger units wherever geographically feasible and adequate facilities for follow up and assessment should be maintained. The present pacemaker caseload in the province is slightly over 350 patients per year. Attempts should be made to do some of pacemaker implants on an NFA basis but the operating room suites in these areas and the supportive services should be at par with those in the main operating room in our hospitals. This will potentially reduce the hospitalization costs of these patients.

13. Since with time an increased number of elderly benefit from newer developments in cardiac therapeutics, both medical and surgical, no patient should be denied the treatment on the basis of age alone.

14. It is essential to continue to maintain high calibre nursing service in all areas related to cardiac care. Of equal importance is also nurse clinician personnel and the educational programs that are capable of producing this type of manpower. At the present time this function is very successfully practiced on Cardiovascular and Thoracic Surgical Services at St. Boniface General Hospital and at the Health Sciences Centre, where a good number of functions previously performed by other professionals are successfully fulfilled by these individuals with the same degree of expertise.

15. Since there is a significant reduction in the mortality rate from coronary artery disease and allied problems on this continent over the past 25 years, sound and aggressive public educational measures should be implemented for all ages starting at school levels relative to prevention of atherosclerosis and coronary artery disease.

16. There should be a well defined policy and mechanism for provision of implementation of new developments in Cardiac Sciences such as cardiac transplantation, treatment of complex cardiac rhythm disorders and others to allow proper structured utilization of these new advances in our region.

VII. APPENDICES

1. Manitoba Medical Utilization For Ischemic Heart Disease
2. Manitoba Hospital Utilization for Ischemic Heart Disease
3. Pacemaker Service in Manitoba
4. Projected Caseload For Invasive Cardiovascular Investigations in Mantioba - 1985 - 1995
5. Manitoba Projected Population By Sex and Age Group
6. Projected Cardiac Surgical Caseload in Manitoba - 1984 - 1995
7. Projected Caseload for Invasive Cardiovascular Investigations in Manitoba - 1985 - 1995

APPENDIX 1

TABLE 1

MANITOBA MEDICAL UTILIZATION* FOR ISCHEMIC HEART DISEASE (410-414) BY REGION AND LOCATION OF SERVICE DELIVERY

1983/84

REGION OF RESIDENCE	ESTIMATED NUMBER OF PATIENTS**	ACTUAL NUMBER OF SERVICES	% OF SERVICES BY LOCATION OF SERVICE DELIVERY			
			LOCAL	WINNIPEG	OTHER	O.O.P.
Central	2,673	16,115	65	28	7	-
Eastman	1,979	11,931	50	43	5	1
Interlake	1,627	9,811	48	48	4	-
Norman	892	5,381	67	21	11	1
Parklands	1,672	10,083	77	10	13	-
Westman	4,051	24,427	90	6	3	1
Winnipeg	24,709	148,996	98	-	2	-
Manitoba	37,603	226,744				

* Manitoba Residents Only

** Number of patients estimated based on the actual number of services ÷ the average number of services per patient in the same category for the province as a whole.

Source: Manitoba Health Services Commission E44740CRPTI and E44740FRPT

APPENDIX 2

TABLE 2

MANITOBA HOSPITAL UTILIZATION* FOR ISCHEMIC HEART DISEASE (410-414) BY REGION OF RESIDENCE

1983/84

REGION OF RESIDENCE	CASES	DAYS	A.L.O.S.	RATE/1000 POPULATION	
				CASES	DAYS
Central	691	8,222	11.9	8	89
Eastman	498	4,593	9.2	6	59
Interlake	367	3,432	9.4	5	50
Norman	311	2,215	7.1	4	29
Parkland	535	4,976	9.3	11	98
Westman	931	14,468	15.5	8	120
Winnipeg	3,547	53,589	15.1	6	88
Manitoba	6,880	91,495	13.3	6	84

* Manitoba Residents Only

Source: Manitoba Health Services Commission Report E44746ERPT

APPENDIX 3

SUNG-WHAN KIM, M.D., F.R.C.S.(C)
CARDIOVASCULAR AND THORACIC SURGERY
LA VERENDRYE PLACE — 404-400 TACHE AVENUE
WINNIPEG, MANITOBA, CANADA
R2H 3C3

TELEPHONE: OFFICE 233-1675

June 3rd 1985

Dr. J. Barwinsky, Director
Provincial Program in Cardiac Surgery
408 - 400 Tache Avenue
Winnipeg, Manitoba
R2H 3C3

Dear Dr. Barwinsky:

RE: Pacemaker Service in Manitoba

This report was prepared upon your request. As Director of Pacemaker Clinic of St. Boniface General Hospital I would like to present Pacemaker Service in two categories:

1. St. Boniface General Hospital Pacemaker Service and
2. Pacemaker Service in Manitoba

A. PACEMAKER SERVICE IN ST. BONIFACE GENERAL HOSPITAL:

1. Pacemaker related surgical procedure and insufficient allocation of operating time.

Table 1. Pacemaker related surgery - S.B.G.H.

	1980	1981	1982	1983	1984	1985 (Jan. - May)
New Implants	104	107	110	98	123	(60)
Re-implants	58	35	22	15	26	(11)
Other pacemaker related surgery	5	4	7	18	14	(6)
Total	167	146	139	131	163	(77)

From this data pacemaker related surgery at St. Boniface General Hospital

(S.B.G.H.) has been 150 + 10 procedures per year. For the past ten years since 1975 Pacemaker O.R. time has been three and a half hours (one afternoon O.R. time) per each week. Each pacemaker implantation procedure requires one and a half hours. This O.R time allows maximum of one hundred pacemaker procedures per year, and remaining fifty procedures have to be schedule in emergency slot.

In reality about fifty percent of the pacemaker requiring patients have life-threatening cardiac arrhythmias and these patients cannot be dealt as elective surgical patients. Recommendation to alleviate this problem is to allocate evenly spaced two half days O.R. time per each week (i.e. Monday and Thursday or Tuesday and Friday).

2. Inadequate EKG monitoring facility.

Majority of pacemaker patients require EKG monitoring prior to and after pacemaker implantation. Presently they are monitored at C.C.U. (Coronary Care Unit) or C.V.T. Stepdown Unit. In uncomplicated pacemaker patients the patient can be monitored on the ward with remote EKG telemetry. C.C.U. has one and C.V.T. has two EKG telemetry devices and this number is insufficient. Many of the open-heart surgery patients require extended period of EKG monitoring for postoperative cardiac arrhythmias. Recommendation is to place another eight channel remote EKG telemetry system on C.V.T. service.

3. Needs of Pacemaker Clinic Service in terms of Manpower and Computerized Data Generation and follow-up.

Table 2. Pacemaker Clinic Patient Follow-up

	1980	1981	1982	1983	1984
Total Patients Registered	430	480	542	614	654
Patient Follow-ups:					
Clinic Visit	836	956	941	1032	1130
In-Hosp. Visit	213	260	268	261	260
Emergency Dept.	21	15	11	15	16
Home Visit	3	9	5	4	6
EKG Telephone Assessment	179	218	189	145	132
Submitted EKG Assessment	53	67	101	93	115

Presently Pacemaker Clinic of S.B.G.H. is manned by one Director (Dr. S.W. Kim), two RNs (one RN - full time, another RN - 0.5 code part time) and one full time clerk. Pacemaker patients to be followed have been growing in numbers with fifty patients increase per year on the average.

Present manpowers are barely capable to cope in patient follow-up. When total pacemaker registry reaches more than seven hundred patients, we will need two full time RNs, and this will be in 1986.

As pacemaker registry grows steadily it has been very difficult to store and retrieve patient related information, pacemaker related information and its performance. In order to make Pacemaker Clinic function efficiently computerized data generator and follow-up system is necessary. In view of steady growth of pacemaker registry at least ten megabite computer with input and output terminals and word processor is considered minimum requirement.

4. Pacemaker Equipment Budget, S.B.G. H.

Pacemaker technology has been advancing steadily and variety of pacemaker products are available. The trend nowadays is increasing number of:

1. Dual Chamber Pacemaker for physiologic pacing and
2. of programmeable pacemaker

Present practice at S.B.G.H. is to use:

30% - Dual chamber pacemaker

40% - Multiprogrammeable ventriculat pacemaker

30% - Three function programmeable pacemaker

Table 3. Pacemaker Equipment Cost per 100 New Patients

		Cost	No. of Pts.	Sub-Total
1.	Dual Chamber Pacemaker	$ 5,200.	X 30	$ 156,000.00
	Two pacemaker leads ($500.00 each)	1,000.	X 30	30,000.00
2.	Multiprogrammeable Pacemaker	3,100.	X 40	124,000.00
	One pacemaker lead	500.	X 40	20,000.00
3.	Three Function programmeable pacemaker	2,200.	X 30	66,000.00
	One pacemaker lead	500.	X 30	15,000.00
			GRAND TOTAL	$ 411,000.00

In each year Pacemaker Budget was submitted to S.B.G.H. Finance Department but actual budget allocated for the Pacemaker Equipment has always been far less than the submitted projection. Rectification of this disparity is recommended.

5. Needs of Electrophysiology Back-up for management of malignant cardiac arrhythmias

This subject will be dealt with in the Subject of Pacemaker Service in Manitoba.

B. PACEMAKER SERVICE IN MANITOBA:

1. Pacemaker surgery and follow-up in Manitoba.

Presently pacemakers are implanted at five different hospitals in Manitoba. The following data was obtained informally through telephone conversations and the numbers of pacemaker surgery are approximate and not exact figure except for S.B.G.H.

	1984 Total Implants	Pacemaker Clinic
S.B.G.H.	149	YES
H.S.C.	100 ± 10	YES
Misericordia G.H.	30 ± 5	YES
Victoria G.H.	20 ± 5	To S.B.G.H.
Brandon G.H.	25 ± 5	YES

TOTAL (Approximately 325)

Guidelines for viable pacemaker services in hospitals by National Health and Welfare of Canada (1979) recommends minimum average caseload of approximately twenty-five new implants per year. Misericordia and Victoria general hospitals meet standard of minimum caseload barely. Brandon General Hospital is acceptable for pacemaker program in view of remote geographical area from major pacemaker centers (S.B.G.H. and H.S.C.).

It is recommended to implant all the pacemaker in the operating room in sterile condition. In order to do this, portable fluoroscopy and image intensifier is absolutely necessary. If pacemaker program is allowed in Misericordia and Victoria hospitals, the province should provide the above equipment.

...../5

2. Needs of Electrophysiology Back-up for management of malignant cardiac arrhythmias.

Cardiac surgery or cardiac pacing for life threatening refractory tachyarrhythmias has not been established in the Province of Manitoba. Presently two patients with implantable defribillator were registered at S.B.G.H. Pacemaker. These two patients received the above device in London, Ontario. A. good functioning Electrophysiology Laboratory Unit is needed at the University of Manitoba in order to manage malignant tachyarrhymias by cardiac surgery or anti-tachycardia pacemaker devices.

Respectfully submitting this report,

S. W. Kim, M.D.
Director,
Pacemaker Clinic
St. Boniface General Hospital

SWK:ld

APPENDIX 4

TABLE 2

PROJECTED CASELOAD FOR INVASIVE CARDIOVASCULAR INVESTIGATIONS* IN MANITOBA

1985 - 1995

Year	Pediatric -- 0 - 14 yrs	Adult -- 15+ yrs
Base Rate Per 100,000 Population	79.21	165.59
1985	188	1372
1986	188	1392
1987	188	1410
1988	188	1428
1989	187	1443
1990	187	1458
1991	186	1471
1992	185	1482
1993	183	1492
1994	181	1501
1995	178	1509

*Includes all cardiac angiography and cardiac catheterizations

Source: Table CI Manitoba Project Population by Sex and Age Group (in 000's) both sexes 1983 - 2006. Manitoba Bureau of Statistics. (see attached appendix)

APPENDIX 5

ABLE C1: MANITOBA PROJECTED POPULATION BY SEX AND AGE GROUP
(IN 000'S) BOTH SEXES

	AGE			
	0 - 14	15 - 64	65 +	TOTAL
1983	239.2	681.0	127.0	1047.2
1984	238.6	688.3	129.4	1056.4
1985	237.8	696.1	132.4	1066.4
1986	237.0	704.8	135.8	1077.5
1987	236.9	712.2	139.4	1088.4
1988	236.8	719.6	142.7	1099.1
1989	236.7	725.8	145.9	1108.3
1990	235.8	731.6	148.9	1116.3
1991	234.5	737.0	151.5	1122.9
1992	233.0	741.0	154.2	1128.3
1993	231.3	744.7	156.4	1132.4
1994	228.7	748.2	158.4	1135.2
1995	225.3	751.0	160.5	1136.9
1996	221.3	753.8	162.4	1137.5
1997	216.4	756.8	164.2	1137.6
1998	211.1	760.6	165.6	1137.4
1999	206.1	764.1	166.7	1136.9
2000	201.4	767.1	167.6	1136.1
2001	196.6	769.9	168.7	1135.1
2002	192.0	772.7	169.2	1133.8
2003	187.4	775.0	169.7	1132.4
2004	183.2	777.1	170.6	1130.7
2005	179.2	778.6	171.2	1129.0
2006	175.8	779.0	172.5	1127.0

APPENDIX 6

PROJECTED CARDIAC SURGICAL

CASELOAD IN MANITOBA

1984 - 1995

YEAR	PEDIATRIC - 0 - 14 YEARS			ADULT - 15+ YEARS		
Base Rate Per 100,000 Population	Open Heart 25.08	Closed Heart 12.96	Total 38.04	Valves 17.33	CABG 50.00	Total 67.33
1984	59.84	30.92	90.76	141.71	408.85	550.56
1985	59.64	30.82	90.46	143.58	414.25	557.83
1986	59.44	30.72	90.15	145.68	420.30	565.99
1987	59.41	30.70	90.12	147.58	425.80	573.38
1988	59.39	30.69	90.08	149.44	431.15	580.59
1989	59.36	30.68	90.04	151.07	435.85	586.92
1990	59.14	30.56	89.70	152.59	440.25	592.84
1991	58.81	30.39	89.20	153.98	444.25	598.23
1992	58.44	30.20	88.63	155.14	447.60	602.74
1993	58.01	29.98	87.99	156.16	450.55	606.71
1994	57.36	29.64	87.00	157.11	453.30	610.41
1995	56.61	29.20	85.70	157.96	455.75	613.71

Source: Table CI - Manitoba Projected Population by Sex and Age Group (in 000's) both sexes 1983 - 2006. Manitoba Bureau of Statistics (see attached appendix)

APPENDIX 7

[illegible]

PROJECTED CASELOAD FOR INVASIVE CARDIOVASCULAR INVESTIGATIONS* IN MANITOBA

1985 - 1995

YEAR	TOTAL PROCEDURES	SBGH PROCEDURES	HSC PROCEDURES
1985	1372	951	421
1986	1392	965	427
1987	1410	977	433
1988	1438	990	438
1989	1443	1000	443
1990	1458	1010	448
1991	1471	1019	452
992	1482	1027	455
1993	1492	1034	458
1994	1501	1040	461
1995	1509	1046	463

* Includes all cardiac angiography and cardiac catheterizations

Ratios between institutions based on Dr. Corbett's report of November, 1984

REVIEW

OF

CONTINUING CARE PROGRAM:

RECOMMENDATIONS FOR INTEGRATION

IN HOSPITAL BED PLANNING

SUBMITTED BY:

CONTINUING CARE SUB-COMMITTEE TO THE
HEALTH SERVICES REVIEW COMMITTEE

May, 1985

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Appendix A

THE CONTINUING CARE PROGRAM

The Continuing Care Program in Manitoba, introduced in September, 1974 remains the outstanding program for care at home in Canada. (For more detail see Appendix A). This reputation has resulted from:

a) its comprehensiveness - it is province-wide, it extends services to all age-groups and it offers a wide range of professional and non-professional services.

b) its centralized coordination and policy direction in combination with decentralized service assessment and delivery - access to service is simple; duplication is avoided; continuity from home to hospital and movement from community to community is provided for; consistency in meeting need throughout the province exists.

c) its referral accessibility from any source and entry into the program at any point - there is access wherever need is identified. This accessibility and the policy of the program encourages early identification of need when the ability to remain in the community is first threatened.

d) its coordinated multi-discipline assessment - this provides a comprehensive assessment using various skills, thereby avoiding:

- duplication as seen in provinces where home support services are delivered through separate programs;[1.]
- the layering of assessment as seen in provinces where services are purchased from external sources.[2.]

****

1) The services delivered through Manitoba Home Care, are in some provinces delivered through two or more separate programs. There is a separate full assessment with each program, resulting, to a large degree, in duplicate assessments.

2) In some provinces all services are purchased from separate agencies, with the provinces' Home Care assessment determining only that a service is needed. The external agency for each service needed then make assessment, to determine the amount (usually within stated maximum) and nature of the service. This creates a layering of assessment.

e) its coordinated assessment for home care and personal care placement - this permits an overall assessment for care at one time, therefore leading to the most efficient utilization of both community and facility resources.

f) its support of care by family members - it supports and encourages family participation in the care of family members at home. Relief for family care providers is a major goal of this program.

g) interfacing with hospitals and personal care homes - this facilitates the placement of services in the home thereby leading to earlier discharge from hospital.

h) its cost-effectiveness - while this program is outstanding in its comprehensiveness, it is also outstanding in cost-effectiveness in comparison with other provincial home care programs. More care can be provided in Manitoba before the cost of the alternative level of facility care is reached than in any other province. (Supporting material can be furnished upon request.)

MAJOR POLICY ISSUES AND RECOMMENDATIONS RELATIVE TO THE CONTINUING CARE PROGRAM AND THE INAPPROPRIATE USE OF INSTITUTIONAL RESOURCES

I. CONJOINT PLANNING

The Continuing Care Program provides the key link between the institutional sector (both hospitals and nursing homes) and the community. It must, therefore, be an active partner in developing the way plans and programs that intersect community and institutions are delivered.

> **Recommendation 1:** That a Conjoint Planning Committee (a standing committee) be established:
>
> a) to insure integrated planning of community and institutional sectors.
> b) to review and assess proposals for developing services, and
> c) to monitor and review programs.
>
> That the Conjoint Planning Committee be composed of representatives of: Office of Continuing Care, M.H.S.C.,one representative from the hospital sector, one representative from the personal care home sector, and one representative from the community (appointed by the Minister of Health). This committee will report to the Minister of Health or as the Minister directs.
>
> That any recommendation from the committee for expansion or new programs requires the Minister's approval for funding and appropriations of funds. (See Recommendation 5)

The changing demography of Manitoba with its increasing percentage of the "very" elderly is an indication that the

Continuing Care Program will have an increasingly important role to play in the coming decades. Changes in the age structure and changes in treatment modalities require an additional element.

> Recommendation 2: That in order to maintain the cost-effectiveness of the Continuing Care Program, to avoid fragmentation, and to provide the best service to individuals, any new program, existing program or pilot project must be integrated into the Continuing Care program and planned conjointly.
>
> Recommendation 3: That any identification of gaps and any new proposals to expand programs having components in the community be referred first to the Conjoint Planning Committee.

II. CHANGES IN TREATMENT MODALITIES

Treatment modalities are changing. Some persons who might previously have required hospitalizations can now be treated at home (eg. Central Venous Line; total perental nutrition (TPN). Others who might have stayed a relatively long time in hospital can now leave hospital earlier as long as treatment is continued at home. Also, an increasing number of procedures and surgery can now be done on a N.F.A. basis.

Changes instituted without advance and conjoint planning can produce a number of undesirable outcomes. First, individuals can be sent home without services critical to their recovery because their home circumstances are unknown or because it is assumed that family members will provide the necessary support. Second, the Continuing Care Program may have difficulty in meeting new and sudden substantial demands for service unless it has received adequate notice to request the allocation of additional resources. Third, the service runs the risk of becoming fragmented, less cost-effective and inadequately coordinated with other necessary services because it is not fully integrated into the Continuing Care Program.

> Recommendation 4: That any new service arising out of new treatment modalities be fully integrated into the Continuing Care Program. This should apply whether the service is initiated to be a continuing service or whether it is meant to be a demonstration, pilot or experimental project which will be evaluated before a firm decision is made about its future.

> Recommendation 5: That following a vetting by the Conjoint Planning Committee, a sub-committee to review the implications of new treatment modality be established preparatory to instituting a specific change. This sub-committee, consisting of the appropriate hospital and physician personnel and staff from MHSC and Office of Continuing Care, would be responsible for: 1) identifying the number of persons likely to require Continuing Care Services; 2) estimating the amount and types of services likely to be needed 3) examining the costs and benefits associated with the change; 4) developing a coordinated implementation plan; 5) securing funding to ensure implementation within the current or the next fiscal year; 6) developing a framework for continuing education of professionals and providers so that they are encouraged to maximize the use of the Continuing Care Program.

III. DISCHARGE PLANNING

The cost-effective use of scarce home care services after hospitalization requires that sufficient time be available to mobilize the services needed upon discharge. At the same time, some persons now remain in hospital longer than necessary because neither hospitals nor Continuing Care staff are available on weekends, as it relates to discharge.

> **Recommendation 6:** That discharge planning start upon admission to hospital or as soon thereafter as possible. If continuing clinical instability makes such early planning for specific individuals impossible, these persons may need to occupy an acute bed until they can be appropriately accommodated in the community.
>
> **Recommendation 7:** That the Conjoint Planning Committee consider the need for both hospital staff and qualified Continuing Care intake staff and for resources to be available seven days a week to handle hospital discharges.

IV. CONVALESCENT BEDS

There are elderly individuals who need longer time to recover from hospitalization, and there are persons for whom an elderly spouse could assume full responsibility if recovery was further advanced. Additionally, there are elderly or disabled persons living alone who need more time for instruction as to how to manage on their own. The absence of convalescent beds and the pressure on acute beds too often result in a medical decision to apply for personal care home placement before it has been firmly established that the person cannot recover sufficiently to go home. Once the family makes plans for the placement of a relative, it is difficult to persuade such a family later that the individual can go home.

> Recommendation 8: That consideration be given to establishing appropriately staffed convalescent beds so that the decision as to the locus of discharge can be delayed until some individuals recover sufficiently, to permit a determination as to whether they should go home rather than to a nursing home.

V. BEDS FOR SPECIALIZED CARE

Currently, many of the hospitalized patients who no longer need hospital-based treatment are persons who cannot go home, who are not candidates for rehabilitation and who are not eligible for admission to nursing homes because these facilities are not permitted to provide the specialized care or the very heavy care they require.

> Recommendation 9: That some existing and new long-term hospital beds be specifically designated to care for persons requiring very heavy or specialized care, and that consideration also be given to permitting some existing or new nursing homes to provide a few types of specialized care (e.g. oxygen therapy/tube feeding), on an experimental basis on condition that they are outfitted and staffed appropriately. In view of the high occupancy rate(s) of nursing homes, this innovation should be considered only as new nursing home beds become available.

VI. IN-TRANSIT PATIENTS

Elderly persons in hospital who are awaiting transfer to a personal care home are currently too often referred to and treated as "bed-blockers". In consequence, they and their families become targets for negative attitudes or avoidance on the part of both physicians and hospital staff. Since the availability of a bed in a specific personal care home is not necessarily concurrent with the date on which the person is panelled for discharge, a number of hospital beds will inevitably be occupied by persons in transit to personal care homes. The larger the hospital, the greater the possible number of these persons.

Hospital administration are aware of the number of in-transit persons they are expected to accommodate. Continuing Care monitors the number of in-transit panelled patients and attempts to maintain some balance across hospitals. The capability of achieving a balance is relative to a) the distribution of in-transit persons in a hospital (distribution by sex, level of care and choice of home); and b) the occurring vacancies across personal care homes.

> **Recommendation 10:** That hospitals recognize persons in transit to nursing homes as legitimate occupiers of acute beds and that positive and appropriate attitudes be promoted towards these persons among both physicians and staff;

specifically, that the use of the term "bed-blocker" is actively discouraged.

Recommendation 11: That as a hospital approaches a maximum number of in-transit patients, it can be assured that Continuing Care Program will continue to give high-priority attention to tranferring a person to a nursing home as quickly as possible, to the extent that the number of personal care home vacancies are a match with patient needs.

Recommendation 12: That, in the event that a hospital is experiencing or expects to experience a special problem in this regard, it contact the Continuing Care Program as soon as possible to resolve the problem.

VII. TRIAGING

The poorer health status and the greater prevalence of chronic conditions among the elderly than among younger persons increases the liklihood of their encountering health related crises. In such instances, elderly persons and their families often rely on the use of emergency wards because they have no personal physician or because the personal physician is unavailable for consultation by telephone and/or to visit at home.

The effective use of hospital emergency services requires that the hospital be able to send persons home as soon as possible if admission is not required. In addition, some situations which families perceive as a crisis for which emergency wards are used, could be effectively triaged at home. Such triaging would also have the advantage of reducing anxiety among families whose relatives encounter frequent crises, an anxiety which too often discourages families from continuing their commitment to help their elderly relatives remain at home.

> Recommendation 13: That the issue of emergency hospital use and triage at home be referred to the Conjoint Planning Committee to assess the size of the target group and identify those already on home care, and determine whether the Continuing Care Program should be provided with resources to make intake, nursing and homemaking services available on a 24-hour-a-day basis, to respond to referrals from hospital emergency wards.

> Recommendation 14: That following a positive determination by the Conjoint Planning Committee, a limited pilot project be considered in which the Continuing Care Program would employ a triage team(s) and support services to respond on a 24-hour-a-day basis to serious medical crises among home care recipients and among one specific target population in the community (e.g. persons over age 80) by making a home visit, if necessary. Its findings would determine whether arrangements should be made for hospitalization or whether the person could be treated at home. If the decision is to manage at home, the family would be instructed as to how to deal with the situation and support might be temporarily supplemented by emergency home care services until "regular" resources could be mobilized. Personal physicians would be notified as soon as possible of the action taken by the triage team.

VIII. CARE IN DIFFICULT TO ACCESS AREAS

There is an absence of hospital out-patient services in northern Manitoba. Patients are sometimes admitted or remain in hospital for very simple procedures which in southern communities would be dealt with through out-patient services. In addition, it may be that some residents in need of service are not receiving them. There are very limited personal care or residential resources in the North.

> **Recommendation 15:** That a review of needs of the Northern area be made, involving Office of Continuing Care, Manitoba Health Services Commission, and the Northern Medical Unit.

MAJOR ISSUES AND RECOMMENDATIONS
RELATIVE TO OPERATION OF CURRENT PROGRAM

IX. OPERATIONAL CONSIDERATIONS

Continuing Care should be capable of meeting any demand for service which fits eligibility criteria, working within a specified dollar and human resource allocation. However, its staff positions are subject to reduction and freezes, and it has little or no capacity to replace staff absent for extended periods of time. With some classes of service providers, the service time cannot be increased except as additional positions can be established through the budget estimates process. (e.g. L.P.N.; H.M.C.). While recognizing the need for fiscal planning and control and the limited availability of dollars, more flexibility is required.

> **Recommendation 16:** That budgetting for Continuing Care must accommodate discretionary funds for unforeseen new programs or expenses that are approved by the Conjoint Planning Committee which could not have been estimated within normal growth mechanisms.

> **Recommendation 17:** That the need for a basic staff-to-workload ratio for assessment/care planning be recognized; that assessment/care planning staff positions be released from staff reduction/freeze policies; that adequate term time be made available to cover extended absences.

> **Recommendation 18:** That some means be sought/established to insure flexibility in the recruitment of service providers in those classes affected by staff year status.

Recommendation 19: That administrative supports necessary to sustain management, planning and delivery be made available from centralized departmental administrative services or be established within the Office of Continuing Care.

X. ADMISSION/DISCHARGE PROTOCOL

While considerable emphasis has been placed on discharge planning within hospitals by M.H.S.C. and Office of Continuing Care, less attention has been paid to the nature of information provided to patients and family on admission to support the process toward discharge. The lack of information or misleading information provided by physicians and other hospital personnel can lead to premature patient/family decisions and add to problems at discharge.

Recommendation 20: That M.H.S.C. and Office of Continuing Care develop a written Admission Information Guide to be distributed in orienting physicians and other hospital personnel in responding to care issues of patients and families which arise at admission.

XI. CONTINUOUS REVIEW OF NEEDS

There are new and changing demands for Personal Care Home beds, both in respect to the needs of the elderly requiring placement and in respect to changes in the field of mental retardation. These, together with developments in residential care, impact on the availability of personal care home beds for the increasing elderly population.

Recommendation 21: That there be a review of new and changing demand for personal care home beds to assure optimum utilization of existing facility beds and to identify priority need for any possible extension of facility resources.

XII. NEEDS OF HANDICAPPED

There is an increasing demand for care for the very severely handicapped adult whose care cannot be managed at home and whose needs are not well met in the personal care home. They must remain in hospital or be considered for placement in a personal care home. It is possible that new models for facility or group care could not only meet their need more adequately, but also could be more cost-effective.

> **Recommendation 22:** That M.H.S.C., Office of Continuing Care, the Departments of Housing and Community Services, and organizations of the handicapped develop a long range plan for handicapped persons.

XIII. SELF-CARE SUPPLIES

Admission to Home Care can be prevented, and discharge from Home Care can be effected for those patients who are able to reach a full level of self-care. The unavailability of self-care supplies places self-care out of the reach of most patients whose needs are continuing (e.g. chronic incontinence supplies).

> **Recommendation 23:** That the Conjoint Planning Committee review the need for self-care supplies and the impact on Home Care and the total care system, with a view to recommending appropriate action.

XIV. SUPPORT RESOURCES

The minimum entry level for Home Care is, to a large extent, dependent upon the support resources available as part of normal community living. To prevent premature need for Home Care, support services must exist in the community to encourage self-care as long as possible.

> **Recommendation 24:** That the need for proportional support for services, which can prempt the need for formalized care services, be recognized. (e.g. support services for elderly; health promotion).

XV. HOME CARE LIMITS

Home Care Policy Guidelines identify the upper limits of cost and service that can be provided:

> Cost limits policy provides that the cost of Home Care will not exceed the cost to government of the same level of care in a facility.
>
> Service limits policy is reflected in appropriate management of care at home. Manitoba, unlike many provicnces, has not set arbitrary service limits, electing to remain flexible to move to accommodate new treatment and service combinations when proven workable.

Home Care cannot, however, initiate or continue care in situations that are unsafe for the client, and/or require expending volumes of resources not available. Through experience, it has been found that care at home is not appropriate:

1. where services from Home Care are required on a continuous 24-hour basis (through recurring 8-hour, 12-hour or 24-hour shifts);

2. in high health-safety risk situations where the client is not able, or a family member is not able or available, to supervise care or to act in an emergency;

3. in situations where the care of the person has been found to be unmanageable in the home setting.

In some situations, this service limit is reached before the cost-limit is reached.

> **Recommendation 25:** That present cost-limit and service limit policies be continued, since these are fundamental in maintaining the basic definition of Home Care (i.e. cost of appropriate care not to exceed the equivalent level of facility care).

> **Recommendation 26:** That to maximize service limits, a system be developed for responding to

a breakdown in provision of care at home, through emergency access to hospital.

Recommendation 27: That rather than modifying (increasing) cost limits and service limits, alternative appraoches be developed to respond to clients requiring service care of a level greater than that provided by Home Care and of a level less than that existing in institutions (e.g. group living and special care arrangements).

SUMMARY OF RECOMMENDATIONS

MAJOR POLICY ISSUES AND RECOMMENDATIONS RELATIVE TO THE CONTINUING CARE PROGRAM AND THE INAPPROPRIATE USE OF INSTITUITIONAL RESOURCES

Recommendation 1: Establish Conjoint Planning Committee

That a Conjoint Planning Committee (a standing committee) be established:

a) to insure integrated planning of community and institutional sectors.

b) to review and assess proposals for developing services, and

c) to monitor and review programs.

That the Conjoint Planning Committee be composed of representatives of: Office of Continuing Care, M.H.S.C. one representative from the hospital sector, one representative from the personal care home sector, and one representative from the community (appointed by the Minister of Health). This committee will report to the Minister of Health or as the Minister directs.

That any recommendation from the committee for expansion or for new programs requires the Minister's approval for funding and appropriations of funds.(See Recommendation 5)

Recommendation 2: Integrate Program Development

That in order to maintain the cost-effectiveness of the Continuing Care Program, to avoid fragmentation, and to provide the best service to individuals, any new program, existing program or pilot project must be integrated into the Continuing Care program and planned conjointly.

Recommendation 3: Coordinate Community Program Expansion

That any identification of gaps and any new proposals to expand programs having components in the community be referred first to the Conjoint Planning Committee.

Recommendation 4: Integrate New Services

That any new service arising out of new treatment modalities be fully integrated into the Continuing Care Program. This should apply whether the service is initiated to be a continuing service or whether it is meant to be a demonstration, pilot or experimental project which will be evaluated before a firm decision is made about its future.

Recommendation 5: Review Implications of New Treatment Modalities

That following a vetting by the Conjoint Planning Committee, a sub-committee to review the implications of new treatment modality be established preparatory to instituting a specific change. This sub-committee, consisting of the appropriate hospital and physician personnel and staff from MHSC and Office of Continuing Care, would be responsible for: 1) identifying the number of persons likely to require Continuing Care Services; 2) estimating the amount and types of services likely to be needed; 3) examine the costs and benefits associated with the change; 4) developing a coordinated implementation plan; 5) securing funding to ensure implementation within the current or the next fiscal year 6) developing a framework for continuing education of profes- sionals and providers so that they are encouraged to maximize the use of the Continuing Care Program.

Recommendation 6: Coordinate Hospital Discharges

That discharge planning start upon admission to hospital or as soon thereafter as possible. If continuing clinical instability makes such early planning for specific individuals impossible, these persons may need to occupy an acute bed until they can be appropriately accommodated in the community.

Recommendation 7: Determine Resource Needs for Seven Day Coverage

That the Conjoint Planning Committee consider the need for both hospital staff and qualified Continuing Care intake staff and for resources to be available seven days a week to handle hospital discharges.

Recommendation 8: Consider Use of Convalescent Beds

That consideration be given to establishing appropriately staffed convalescent beds so that the decision as to the locus of discharge can be delayed until such individuals recover sufficiently to permit a determination as to whether they should go home rather than to a nursing home.

Recommendation 9: Designate Beds for Specialized Care

That some existing and new long-term hospital beds be specifically designated to care for persons requiring very heavy or specialized care and consideration also be given to permitting some existing or new nursing homes to provide a few types of specialized care (e.g. oxygen therapy/tube feeding), on an experimental basis on condition that they are outfitted and staffed appropriately. In view of the high occupancy rate(s) of nursing homes, this innovation should be considered only as new nursing home beds become available.

Recommendation 10: Legitimize In-transit Patients
That hospitals recognize persons in-transit to nursing homes as legitimate occupiers of acute beds and that positive and appropriate attitudes be promoted towards these persons among both physicians and staff, specifically, that the use of the term "bed-blocker" be actively discouraged.

Recommendation 11: Priorize Transfers
That as a hospital appraoches a maximum number of in-transit patients, it can be assured that Continuing Care Program will continue to give high-priority attention to transferring a person to a nursing home as quickly as possible, to the extent that the number of personal care home vacancies are a match with patient needs.

Recommendation 12: Refer Special Problems
That, in the event that a hospital is experiencing or expects to experience a special problem in this regard, it contact the Continuing Care Program as soon as possible to resolve the problem.

Recommendation 13: Determine Need for Triaging
That the issue of emergency hospital use and triage at home be referred to the Conjoint Planning Committee, to assess the size of the target group and identify those already on home care, and determine whether the Continuing Care Program should be provided with resources to make intake, nursing and homemaking services available on a 24-hour-a-day basis to respond to referrals from hospital emergency wards.

Recommendation 14: Develop Triaging Pilot Project
That following a positive determination by the Conjoint Planning Committee, a limited pilot project be considered in which the Continuing Care Program would employ a triage team(s) and support services to respond on a 24-hour-a-day basis to serious medical crises among home care recipients and among one specific target population in the community (e.g. persons over age 80) by making a home visit, if necessary. Its findings would determine whether

arrangements should be made for hospitalization or whether the person could be treated at home. If the decision is to manage at home, the family would be instructed as to how to deal with the situation and its care resources could be temporarily supplemented by emergency home care services until "regular" resources could be mobilized. Personal physicians would be notified as soon as possible of the action taken by the triage team.

Recommendation 15: Review Needs of the North

That a review of needs of the North be made, involving Office of Continuing Care, Manitoba Health Services Commission, and Northern Medical Unit.

MAJOR ISSUES AND RECOMMENDATIONS RELATIVE TO OPERATION OF CURRENT PROGRAM

Recommendation 16: Allow Flexible Budgetting

That budgetting for Continuing Care must accommodate discretionary funds for unforeseen new programs or expenses that are approved by the Conjoint Planning Committee which could not have been estimated within normal growth mechanisms.

Recommendation 17: Recognize Staff/Workload Ratios

That the need for a basic staff-to-workload ratio for of assessment/care planning be recognized; that assessment/care planning staff positions be released from staff reduction/freeze policies; that adequate term time be made available to cover extended absences.

Recommendation 18: Allow Flexibility in Staff Recruiting

That some means be sought/established to insure flexibility to the recruitment of service providers in those classes affected by staff year status.

Recommendation 19: Provide Administrative Supports

That administrative supports necessary to sustain management, planning and delivery be made available from centralized departmental administrative services or be established within the Office of Continuing Care.

Recommendation 20: Develop Admission Information Guide

That M.H.S.C. and Office of Continuing Care develop a written Admission Information Guide to be distributed in orienting physicians and other hospital personnel in responding to care issues of patients and families which arise at admission.

Recommendation 21: Review Changing Demand for Services
That there be a review of new and changing demand for personal care home beds to assure optimum utilization of existing facility beds and to identify priority need for any possible extension of facility resources.

Recommendation 22: Review Needs of Handicapped
That M.H.S.C., Office of Continuing Care, the Departments of Housing and Community Services, and organizations of the handicapped develop a long range plan for handicapped persons.

Recommendation 23: Review Need for Self-Care Supplies
That the Conjoint Planning Committee review the need for self-care supplies and the impact on Home Care and the total care system, with a view to recommending appropriate action.

Recommendation 24: Recognize Need for Proportional Support Services
That the need for proportional support for services, which can prompt the need for formalized care services, be recognized (e.g. support services for elderly; health promotion.

Recommendation 25: Continue Present Policies for Cost Limits and Service Limits
That present cost limit and service limit policies be continued, since these are fundamental in maintaining the basic definition of Home Care (i.e. cost of appropriate care not to exceed the equivalent level of facility care).

Recommendation 26: Provide Emergency Access to Other Services to Accommodate Service Limits
That to maximize service limits, a system be developed for responding to a breakdown in provision of care at home, through emergency access to hospital.

Recommendation 27: Develop Alternative Approach to Accommodate Services in Excess of Limits
That rather than modifying (increasing) cost limits and

service limits, alternative approaches be developed to respond to clients requiring service/care of a level greater than that provided by Home Care and of a level less than that existing in institutions (e.g. group living and special care arrangements).

APPENDIX A

OFFICE OF CONTINUING CARE

Program Overview

The Office of Continuing Care is responsible for the province-wide coordination of Home Care and for assessment for placement into personal care homes. It provides one network of province-wide assessment for care. The office has responsibility for program direction and management including the establishment and maintenance of standards, program monitoring and evaluation, staff development, and liaison with other components of the health care system.

The program is delivered through the department's regional offices and sub-offices, and through five designated rural health centres. In Winnipeg there is also service delivery coordinated through offices based in four hospitals, and short term services (under 60 days) are delivered through the Victorian Order of Nurses.

Home Care

Home Care is provided to those who would otherwise require hositalization or require placement in a care facility or whose condition, without services, would place them at risk of placement/hospitalization.

a) Provides a wide range of services for care at home including: household maintenance services, personal care services, nursing services, therapy services, volunteer service (shopping, transportation, telephone assurance, etc.) and supplies and equipment.

b) Service provided meets need which the client, family members or other community services cannot meet.

c) There is no charge for services provided at home; service provided is the minimum amount needed to support independence; but at the minimum skill/cost level necessary to meet need.

d) The cost of service to any person does not exceed the cost to government of the equivalent level of institutional care except for periods of acute care, terminal care, for persons approved for and awaiting placement.

Recent development of several program components: The Continuing Care Program continues to expand the concept of independent living for the physically disabled; homemaking, personal care and home care attendant/orderly services are provided to approximately 50 individuals living in the community in specially modified apartments known as FOKUS I, II, and III units, and in the Lutheran Housing unit. Preliminary development also occurred in 1983 toward a FOKUS-type project at The Pas, and potential development for a FOKUS IV in Winnipeg.

The Home Care Program recruits and provides part-time community employment for professionals and para-professionals. Approximately 2,000 persons are employed on part-time basis to deliver homemaking and personal care services per month. In addition, approximately 200 Registered Nurses, 100 Licensed Practical Nurses and 200 Home Care Attendants provide nursing and personal care services. Therapy services are provided through Community Therapy Services of Manitoba. The program benefits from the work of volunteers who provide services such as meal delivery, friendly visiting, transportation, and daily telephone reassurance.

In December, 1983, 12,651 citizens received home care services. This comprised 280 children (under age 19), 2,506 adults age 19 to 64, and 9,865 older citizens age 65 and over.

The services provided included homemaking, personal care, nursing, therapy, relief and respite services, supplies and equipment as well as planned referral to hospital resources (speciality clinics, assessment, day hospital), and community services for volunteer transportation, shopping, etc.

The services, based upon assessment of health and home functioning were provided daily, twice weekly, bi-weekly, overnight or for short periods of twenty-four hour care.

Personal Care Home Placement

Placement into a Personal Care Home is facilitated for those whose care can no longer be managed at home in the community. Eligibility for entrance is contingent upon a panelling process that reviews the needs of all applicants. Home Care services interface with this process, providing care where appropriate, until placement can be made.

In December, 1984, there were 1,800 on the waiting list for Personal Care Home placement, having been approved by an assessment panel for placement: 701 in rural regions and 1,099 in Winnipeg. Of all awaiting placement, 768 were waiting in hospital and 1,032 were at home.

Service Delivery and Management

1) There is central coordination through the Office of

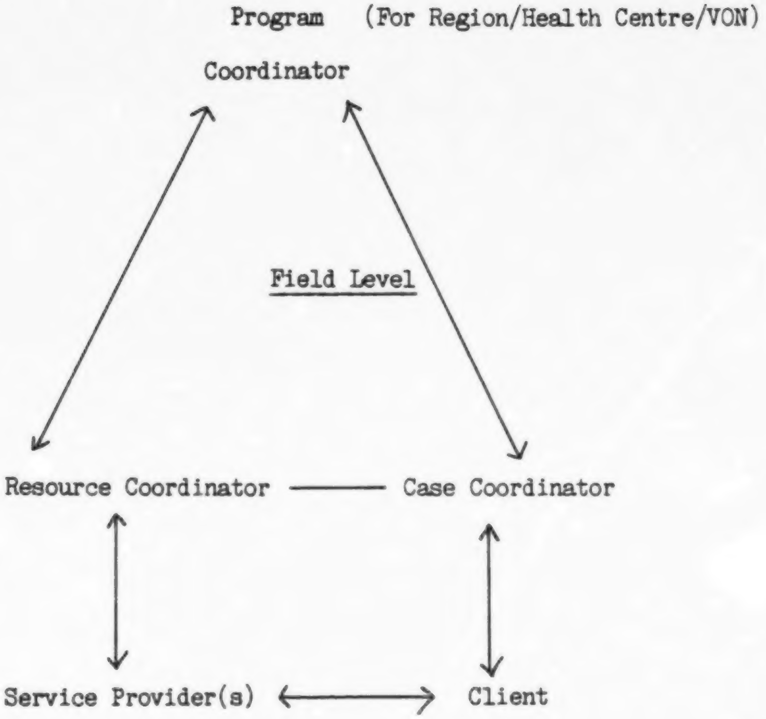
Continuing Care to:

a) assure province-wide achievement of objectives and to assure an integrated network for Home Care and placement for all communities;

b) to assure planned effective inter-face with hospitals and personal care homes;

2) There is decentralized delivery of services through eight departmental regions and their area offices, through Health Centres and, in the case of short-term care in Winnipeg, through the Victorian Order of Nurses. This decentralized delivery assures access to citizens at the local level and that program implementation will accommodate local needs and resources.

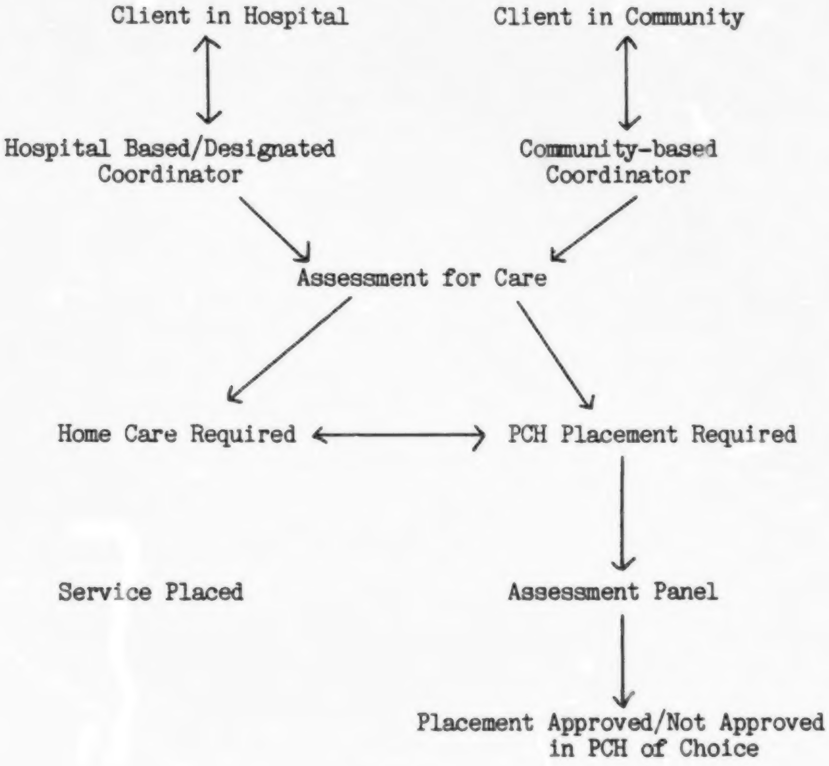
3) The key delivery component which is replicated through regions, Health Centres and the V.O.N. is:
(See next pages)


Program (For Region/Health Centre/VON)
Coordinator
Field Level
Resource Coordinator
Case Coordinator
Service Provider(s)
Client

- One person has overall responsibility for program implementation for the region/centre/agency.

- There is coordinated assessment of client need and of service delivery with immediate, direct communication so that resources needed will be developed and made available and/or that the service mix is adjusted to in fact meet need.

4) Client Access to Service (Home Care or Placement)


Client in Hospital
Client in Community
Hospital Based/Designated Coordinator
Community-based Coordinator
Assessment for Care
Home Care Required
PCH Placement Required
Service Placed
Assessment Panel
Placement Approved/Not Approved in PCH of Choice

With the field level component existing at the most local level, there is immediate client acccess to service.

Program Planning, Review

Each region, health centre, agency plans/implements for their geographic area; the central Office of Continuing Care is responsible for planning with province-wide implications. The standard is that each case is reviewed as required, or minimally, every three months; each caseload is reviewed once a year and the overall program in each region/health centre/agency is reviewed once a year. Staff of the Office of Continuing Care and senior Region/Centre/Agency staff participate in caseload and program reviews.

Limitations of the Home Care Program

A portion of persons utilizing hospital beds do so because the Home Care Program cannot meet their needs on a continuous 24-hour/seven days per week basis, and family/home supports do not exist to augment the home care services. Thus, these cases occupy hospital beds because it is the facility available that can most closely meet their health care needs.

Limited Flexibility of Utilizing Payroll Service Providers

The absence of a comprehensive manpower system for payroll staff (currently employed only on casual basis) has limited the workload commitments that service providers make to the program. The absence of job security provisions - pensions, sick leave, etc. - result in a limited number of staff willing to work assignments requiring weekend call and late hours. In Winnipeg, the hiring is limited by the imposed budgetary structure for R.N.'s and L.P.N.'s who are in a bargaining unit, restraining flexibility in employing additional hours of staffing, resulting in the program over-utilizing the more accessible and costly services (purchased from V.O.N.).

Affects of Understaffing on Program Discharges

The Home Care Program is experiencing a backlog of patients moving through the system because understaffing of professional case coordinating staff has prevented case review according to the recommended guidelines of three month intervals. Thus, a smooth flowing continuum of services and possible ultimate discharge of cases is not occurring at an optimal rate. This is affecting the pace at which cases are discharged and admitted to the Program, adding to the backlog of persons awaiting entry into the Program.

Case coordinator/patient ratios required, derived from a field-tested workload formula for case coordination and from demonstrated field experience are as follows:

Rural	50-70 per case coordinator
Winnipeg	80-100 per case coordinator
Province	70-80 per case coordinator

The attached table reflects the trend during the past two years:

CASELOAD GROWTH

REGION	AVERAGE CASELOADS PER CASE COORDINATOR		
	APRIL 1983	MARCH 1984	PERCENT INCREASE
Winnipeg	123	142	15.5
Central	55	61	10.9
Eastman	65	90	38.5 (3)
Norman	65	70	7.7
Thompson (city)	26	34	30.8 (4)
Interlake	95 (1)	109 (1)	14.7
Parkland	60	90	50.3 (3)
Westman	128 (1)	82 (1 & 2)	-35.9

****

(1) Only separated caseloads are shown. The shared caseloads were 42/46 in Interlake and 42/44 in Westman.

(2) An additional coordinator was added in Westman to achieve reduced caseloads at end of 83/84 fiscal yiear.

(3) The large extent of the increase in Eastman and Parkland has occurred in part by reason of insufficient staff positions for the assignment to Continuing Care on separation. Such will also occur in Norman and Interlake if sufficient positions are not made available with separation.

(4) In view of the small numbers in this region, percentages always appear high.

Need for Community Support Services for the "Well Elderly"

To prevent premature need for Home Care, support services to the "well elderly" must exist in the community to enhance their well status as long as possible. Many such support services do not exist yet in Manitoba, and thus, a portion of cases entering Home Care do so because supports were not available to slow their rate of deterioration.

Administrative Need for Computerized Client Tracking System

The present manual record keeping system of cases does not lend itself to ongoing monitoring of cases that move from one home care/hospital service to another—client tracking. It also prevents adequate program monitoring/review needed for adjusting present programs and planning new services.

Need for Demonstration Projects on Alternate Delivery System

The prospects for extending Home Care to address increasing demand for heavier and more special type treatment compels the need to develop demonstration projects to test alternate delivery models. The Deer Lodge study is such an example, exami type treatment compels the
need to develop demonstration projects to test alternate

delivery models. The Deer Lodge study is such an example, examing the feasibility of an Intermittent Hospital/Home Care Program. Other projects could include demonstrating the flexibility of trans- ferring the FOKUS-type group service concept to groups of elderly living in the community, and its cost efficiency over the current one-to-one service planning for some clients.

Program Delivery Structure - Winnipeg

With the shift in hospitals to discharge more long-term care and the need for more vigorous community care/hospital planning, the role of the Victorian Order of Nurses in hospital discharge, in coordination of hospital-related Home Care cases and in providing nursing to the long term Home Care program requires review.

Population Projections

Statistics Canada population projections (based on the 1981 Census) indicate persons age 65+ represented 12.1% of Manitoba's total population in 1983, and this portion will increase to 15.3% of the total population in the year 2006. Conversely, the group age 0-14 will decrease from 22.8% of the total population in 1983 and to 15.6% in 2006; with the group age 15-64 changing less, from 65.0% of the total population in

1983 to 69.1% in 2006.

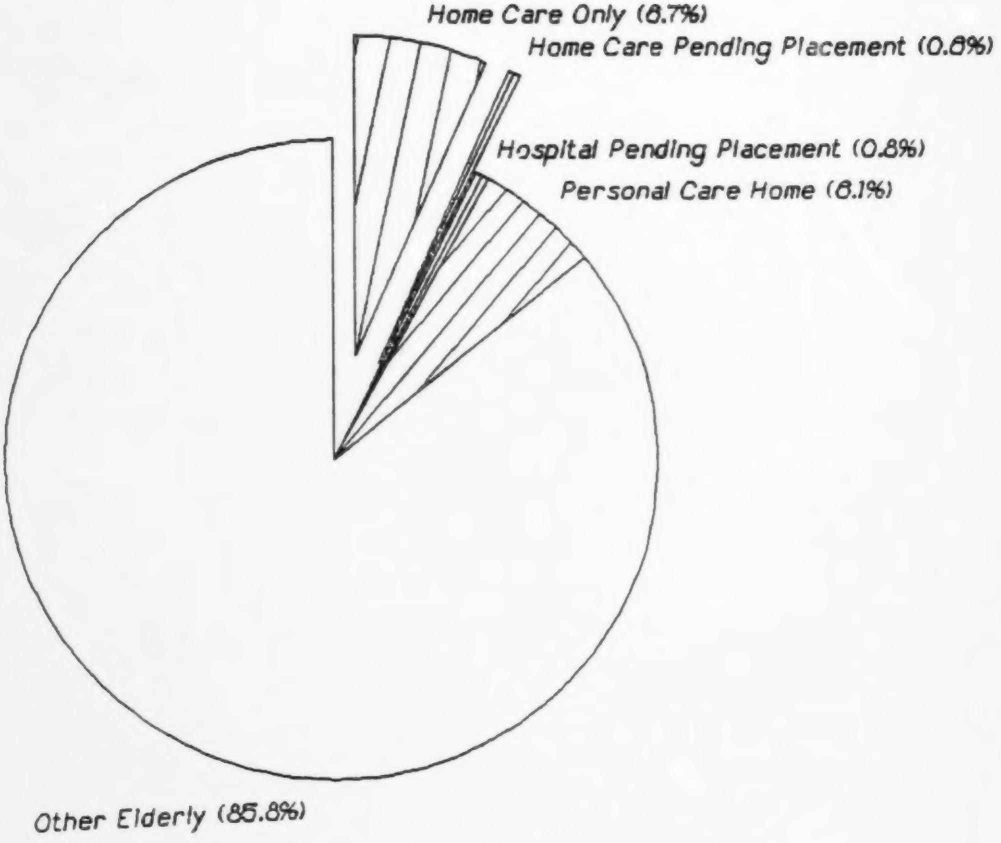
The group age 65+ is projected to increase by 26.5% between 1983 and 2006—from 127,000 to 172,500, or an increase of 45,500 persons. It should be noted that approximately 7% of this group now requires Home Care Services at any one time. Thus, a projected increase of 3,185 persons age 65+ might require Home Care services at any given point in time by the year 2006. What is most important for Home Care is:

i) there are more severely disabled reaching adulthood and more adults severely disabled (accidents) or experience degenerative disabling conditions who are looking for services to support care at home rather than institutional care.

ii) there is currently, and for the next decade, a higher than usual wave passing through our population, of "unattached" adults resulting from factors associated with the second world war. This is increasing the number of aging persons who are without family to assist with care.

iii) while we are experiencing an increasing aging population, experts are predicting improved health and functioning amongst those who are entering the elderly population group (eg. those age 65 - 74. What is important, although the numbers are not as large, is the very high growth rate of those over 75 and especially of those over age 85 who constitute the majority of users of both home care and facility care.

MANITOBA POPULATION 65+



Note: Population figures are from the Manitoba Health Services Commission. The P.C.H. figures are personal care home residents age 65+ as of March 1984.

The Home Care figures are caseload figures age 65+ as of December 1984. The waiting list figures are December 1984. There were 206 people waitng placement who were in the community but not on The Home Care Program.

CONTINUING CARE PROGRAM

CONTINUING CARE OBJECTIVE INDICATORS:

ALTERNATIVE INSTITUTIONAL CARE LEVEL AT ADMISSION TO HOME CARE:

	1983/84
PERSONAL CARE HOME	17%
REMAIN IN HOSPITAL (Longer)	46%
REMAIN AT HOME WITHOUT APPROPRIATE CARE	37%

REASONS FOR DISCHARGE FROM HOME CARE:

	1983/84
PLACED IN PERSONAL CARE HOME	23%
IMPROVED - NO LONGER NEEDS CARE	37%
IMPROVED - ABLE TO MANAGE ON OWN	16%
DECEASED	17%
OTHER	5%

OTHER INDICATORS:

- REDUCED DEMAND LEVEL I HOSTEL CARE (Esp. Winnipeg)
- MORE DISCHARGED FROM HOSPITAL EARLIER
- INCREASINGLY THOSE PLACED ARE SERIOUSLY CONFUSED OR REQUIRE HEAVY PHYSICAL CARE AND FAMILY/HOME CANNOT MANAGE IN COMMUNITY
- HOME CARE COPES WITH HEAVIER CARE
- FAMILY INVOLVEMENT IN PROVIDING CARE CONTINUES AT HIGH LEVEL

CONTINUING CARE PROGRAM

HOME CARE OUTPUT:

WORKLOAD ACTIVITY:

	1983/84
PERSONS ASSESSED/ADMITTED TO HOME CARE	9,761
PERSONS DISCHARGED	9,479
TOTAL RECEIVING HOME CARE IN YEAR	20,392

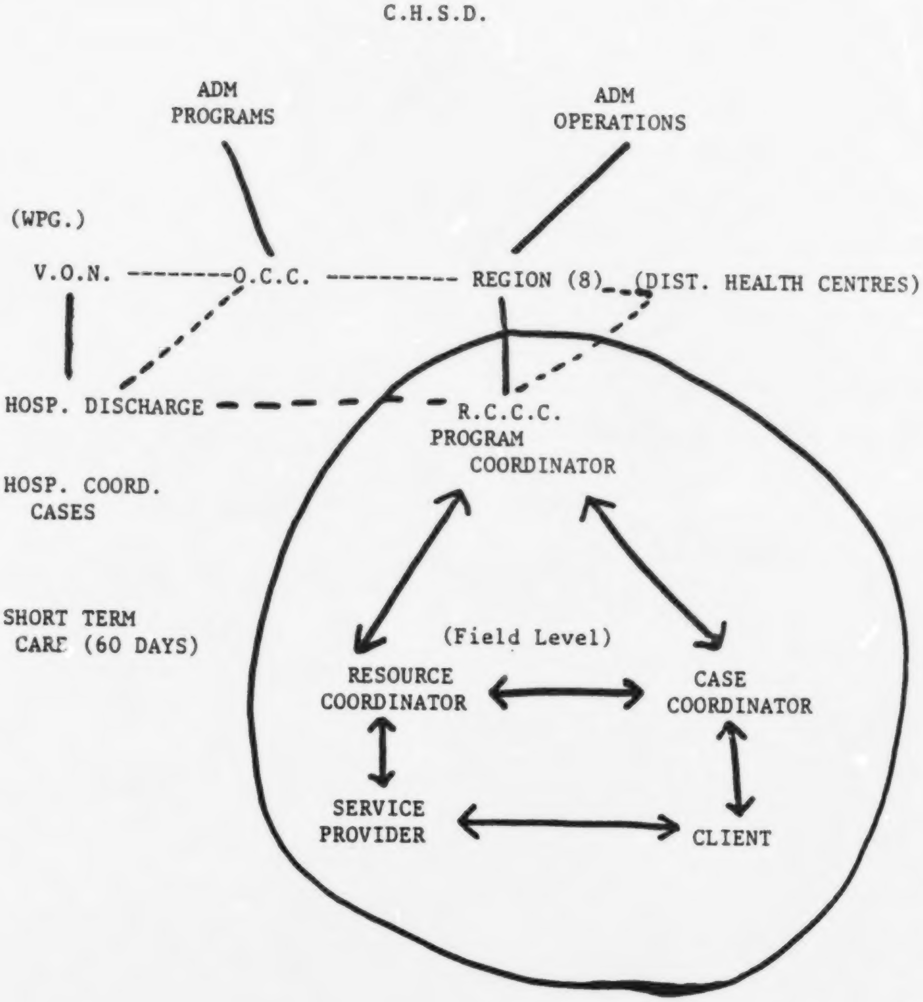
1983/84

AVERAGE MONTHLY RECEIVING/DELIVERING SERVICE/COST

	NUMBER RECEIVING	NUMBER DELIVERING	COST $000
NURSING SERVICES	3,902	222	4,330.3
AUXILIARY SERVICES	2,302	349	3,597.5
THERAPY SERVICES	339	41	240.7
HOMEMAKING SERVICES	6,925	2,039	9,377.0
VOLUNTEER SERVICES	1,300	797	-
OTHER, (Transp.; Training)			1,656.0
			12,251.5

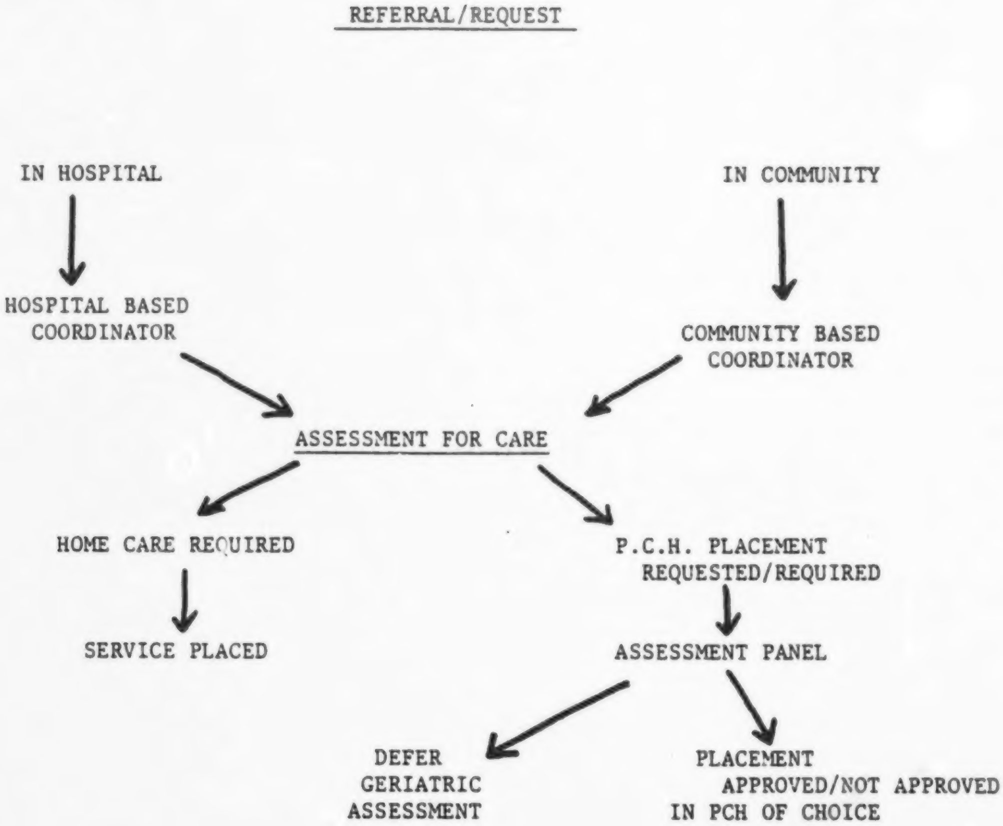
CONTINUING CARE PROGRAM

DELIVERY NETWORK


C.H.S.D.
ADM PROGRAMS
ADM OPERATIONS
(WPG.)
V.O.N.
O.C.C.
REGION (8)
(DIST. HEALTH CENTRES)
HOSP. DISCHARGE
R.C.C.C. PROGRAM COORDINATOR
HOSP. COORD. CASES
SHORT TERM CARE (60 DAYS)
(Field Level)
RESOURCE COORDINATOR
CASE COORDINATOR
SERVICE PROVIDER
CLIENT

CONTINUING CARE PROGRAM

CLIENT ACCESS TO SERVICE


REFERRAL/REQUEST
IN HOSPITAL
IN COMMUNITY
HOSPITAL BASED COORDINATOR
COMMUNITY BASED COORDINATOR
ASSESSMENT FOR CARE
HOME CARE REQUIRED
P.C.H. PLACEMENT REQUESTED/REQUIRED
SERVICE PLACED
ASSESSMENT PANEL
DEFER GERIATRIC ASSESSMENT
PLACEMENT APPROVED/NOT APPROVED IN PCH OF CHOICE

CONTINUING CARE PROGRAM

ASSESSMENT PANELS:

POLICY - M.H.S.C./O.C.C.

OPERATION - REGIONAL DIRECTOR/REGIONAL CONTINUING CARE COORDINATOR

MEMBERSHIP - PHYSICIAN
SENIOR NURSE (B.N.)
SENIOR SOCIAL WORKER (M.S.W.)
MAY INCLUDE SPECIALIST
MAY INCLUDE REPRESENTATIVE OF P.C.H.'S

PRESENTATION - CASE COORDINATOR
MAY INCLUDE APPLICANT
MAY INCLUDE FAMILY/REPRESENTATIVE
MAY INCLUDE APPLICANT'S PHYSICIAN

RESPONSIBILITIES - DETERMINE APPLICATION COMPLETE
DETERMINE ASSESSMENT COMPLETE
DETERMINE NEED FOR P.CH.C. - e.g. care cannot be appropriately managed at home
DETERMINE LEVEL OF CARE
DETERMINE THAT HOME OF CHOICE CAN MEET CARE NEEDS

CONTINUING CARE PROGRAM

MANAGEMENT OF WAITING LIST:

POLICY -	M.H.S.C. AND O.C.C.
OPERATION -	REGIONAL DIRECTOR/REGIONAL CONTINUING CARE COORDINATOR
MANAGEMENT -	WAITING LIST COORDINATOR
ORGANIZED -	BY HOME OF CHOICE BY LEVEL OF CARE BY PRIORITY NEED BY DATE APPROVED
PRIORITIES -	- THOSE IN HOSPITAL WAITING PLACEMENT - THOSE IN COMMUNITY WHO WITH FAMILY AND HOME CARE SUPPORT REMAIN AT RISK - TO ACHIEVE BALANCE IN HOSPITALS
LIMITED WAITING LIST - (where required)	MAINTAINING A LIMITED NUMBER OF APPLICATIONS AT A P.C.H. (3X vacancy rate for each sex and level of care)

CONTINUING CARE PROGRAM

PLACEMENT PROGRAM OUTPUTS:

CASELOAD ACTIVITY

	1983/84	
PERSONS ASSESSED FOR PLACEMENT	2,967	
PERSONS APPROVED FOR PLACEMENT	2,414	
PERSONS ON HOME CARE PENDING PLACEMENT	956	1,092

NUMBER ON WAITING LIST

	Dec. 31st	
	1982	1983
RURAL REGIONS	717	803
WINNIPEG	727	874
TOTAL	1,444	1,677

FIRST ADMISSION TO PCH

	1982	1983
RURAL REGIONS	815	697
WINNIPEG	957	836
TOTAL	1,772	1,538

AVERAGE MONTHLY NUMBER IN HOSPITAL IN WINNIPEG AWAITING PLACEMENT

	1982	1983
ACUTE HOSPITAL	148	162
NON-ACUTE HOSPITAL	155	179
	303	341

REPORT OF THE CRITICAL CARE SUB-COMMITTEE

BACKGROUND

Following the Minister's request that the sub-committee be formed, the Critical Care Sub-Committee met on December 14, 1984. The members were:

Dr. Bryan W. Kirk, Chairman
Dr. A. Banks
Dr. C. Cameron
Ms. M. McLean
Dr. J. Nefkin

Dr. P. McGarry
Dr. J. Horne
Ms. P. MacDonald

Minutes of the meeting are appended (Appendix A). It was possible to discuss most of the issues at one meeting. This was due in part to the existence of the College of Physicians and Surgeons of Manitoba study of northern critical care and transport, and the recent Winnipeg ICU Bed Study. However, we were concerned that the important question of pediatric ICU might not be dealt with by the Pediatric or Obstetric Sub-Committees. It was thus necessary to await the reports of these committees. When the reports arrived it was obvious that Pediatric ICU had "fallen between the cracks". I obtained permission to ask Dr. Cal Cameron to prepare a report and recommendations. This arrived on May 15. We are, therefore, in a position to submit the final report including recommendations on Pediatric Intensive Care.

Critical care is not a traditional subspecialty in that it does not have an organ-systems base. It is rather a broad specialty which cuts across many disciplines and has to do with the application of technology and complex organizations to the treatment of seriously ill patients. Clearly both the community and hospitals contain a spectrum of patients ranging from the nearly well to the desperately ill. This continuum has been represented by various nursing and medical acuity indices and scores. An intensive care or coronary care unit is basically an arbitrary geographical line drawn at an upper end of the continuum which defines an area where equipment, highly trained staff and other resources are concentrated in order to improve the survival of the most seriously ill. Although the line is arbitrary, and the patients may be somewhat dispersed, all critical care has in common special training of staff and complex equipment.

Using this definition, a number of units exist in Manitoba:

RURAL AND NORTH UNITS

The College of Physicians and Surgeons of Manitoba survey (Appendix B) found that ICU's existed in Flin Flon, Thompson and The Pas. (The team did not visit Churchill.) The College report states that while geographical units existed, their effectiveness was dependent upon the availability of appopriately-trained medical and nursing staff. The

College report also found that even with the most effective and accessible air transportation system, it would still be necessary to have in each remote location an area for the resuscitation and stabilization of seriously ill patients prior to transport. Because of the small size of the hospitals and their units, and the migrant nature of northern communities, it has been particularly difficult to maintain adequate numbers of appropriately-trained nursing and medical staff in each northern location. The College report recommended a northern based intensive care nursing course. This recommendation has not been implemented. The College report also recommended a minimal period of formal training for physicians undertaking intensive care, similar to the requirement in Anesthesiology. This requirement has not been enacted to date.

It appears that there are adequate numbers of geographic beds in the north and that the most vexing problems are and will continue to be, staffing and air transportation. Transportation will be discussed below.

The intensive care unit in The Pas is an extremely good one and could serve as an appropriate model for the development of intensive care units in the two adjacent northern communities.

RURAL INTENSIVE CARE

Units exist in Dauphin and Portage La Prairie which provide more than monitored beds. The intensive care unit in Dauphin has been in existence for at least 15 years and has served the local community well. It is a model of a small regional unit. Many hospitals have monitored beds, i.e. Selkirk and Morden. These beds are used primarily for patients with uncomplicated acute myocardial infarction and for post-operative patients. These monitored beds do not exist as separate units but are staffed by the nursing staff from the general medical or surgical wards. There appears to be no dissatisfaction with the provision of this type of care in the rural communities. There does not appear to be much projected growth in this activity.

URBAN COMMUNITY HOSPITALS

Larger multi-purpose, staffed units exist at the Brandon General Hospital, Grace, Victoria, Misericordia, Concordia, and Seven Oaks Hospitals. These units provide not only monitoring, but they also share the ability to carry out some invasive monitoring and mechanical ventilation. All have a nucleus of qualified intensive care nurses, sometimes supplemented by other staff. Each unit has a director and a group of attending physicians, anesthetists and surgeons, who provide supervision of care. The unit at the Brandon General Hospital is particularly important to the Westman Region of the province. It has operated successfully for many years. The Intensive Care Unit Bed Study (Appendix C) contains a great deal of demographic information concerning the five community hospitals' intensive care units in the City of Winnipeg. Each of these units, like the Brandon unit, are multi-purpose, providing for the care of medical patients and post-operative surgical patients. The bed study shows that the average acuity level of patients in these units lies somewhat below the acuity level of patients in the tertiary hospitals, although there is considerable overlap, as one would expect. The Winnipeg bed study showed that the occupancy rate of intensive care beds in the City of Winnipeg in 1983 was too high. This was related in part to bed closures at the Health Sciences Centre and the Misericordia Hospital. Two years later, with more beds open at both Health Sciences Centre and Misericordia Hospital, there is still a shortage of intensive care beds in the community hospitals in the City of Winnipeg. At the community hospitals, other than the Misericordia Hospital, the intensive care bed shortage is exacerbated by blocked beds, i.e. inability to discharge patients to the medical wards because the beds on the wards are full.

TERTIARY CARE HOSPITALS

The tertiary care level critical care facilities are at the St. Boniface General Hospital and the Health Sciences Centre. These include adult medical, surgical and neonatal units at both hospitals. The Children's Hospital has the only Pediatric Intensive Care Unit in the province. (Some pediatric intensive care is carried on in Thompson.) Pediatric Intensive Care will be dealt with below.

The major discernable trend in both tertiary care hosptials has been the increased acuity and complexity of patients. This has resulted in a greater increase in nursing requirements over the past 15 years. Thus, a nursing complement adequate to keep all adult beds open at the Health Sciences Centre and the St. Boniface Hospital in 1977-78 is now only adequate for one half to two thirds occupancy. This has compounded the effect of the intensive care nursing shortage at the Health Sciences Centre.

The committee projected that there would be a slow increase in the demand for intensive care beds over the next decade due to:

(a) heightened public expectations;

(b) improved transportation from rural and remote areas;

(c) more cardiac surgery;

(d) upgrading of the neurosurgery program;

(e) increased numbers of patients suffering from complications of cancer chemotherapy and transplantation.

It appears obvious that this gradual increase in the number of candidates for intensive care will occur because of the increased acuity level of all patients in hospital. The acuity level of patients in hospital will occur as a result of:

(a) transfer of patients to nursing homes;

(b) NFA surgery and early discharge programs;

(c) development of outpatient diagnostic services;

(d) growth and treatment programs in all disciplines.

Thus, most of the patients in the tertiary care hospitals will be as sick as patients previously admitted to intensive care in the early 1960's.

The committee projected that the difficulties obtaining adequate nursing staff will continue in most parts of the province. The difficulties in any particular year will depend upon the social and economic factors affecting nursing at that time. Equally important will be increased short-fall of medical manpower arising from decreasing numbers of resident staff available to all intensive care units at the tertiary care hospitals. It is believed that this latter problem may become, in the short term, the limiting factor on the number of beds.

PEDIATRICS

Dr. Cal Cameron summarized the situation with respect to the Children's Hospital in his letter of May 15, 1985 (Appendix D). Unfortunately the letter does not deal with seriously ill children outside the Children's Hospital. Dr. Cameron did, however, make important contributions to the College of Physicians and Surgeons report which does address transportation and northern facilities for the seriously ill child. Dr. Cameron projects a slow increase in the demand for pediatric intensive care services resulting from a projected increase in the cardiac surgery, neurosurgery and hematology/oncology areas. He also points to similar physician and nursing shortages in the pediatric area. The big short term problem facing intensive care is the woefully inadequate physical facilities at the Children's Hospital.

TRANSPORTATION

The question of transportation of the critically ill was dealt with in the report from the College of Physicians and Surgeons of Manitoba. The current transportation system is inadequate, both in equipment and operation and administration. It appears likely that the province will replace its air ambulance with a new one this year. It appears less likely that chronic difficulties in co-ordination and communication between remote areas and the Cities of Winnipeg and Brandon will be corrected.

The College recommended that a Medical Director or Transport Co-ordinator be appointed has been adopted. Hopefully Dr. McKenzie will put in place an effective communication system. At the moment, effective communication between remote and northern areas and the tertiary care centres is based on personal connections. These problems should be rather easily corrected. The result of correction will likely be an increase in the numbers of patients transported to Winnipeg.

PROJECTIONS

The committee struggled with the lack of relevant data on intensive care in the province. They pointed out that effective management of any enterprise is difficult without a minimum of adequate information. Most of the data used in preparing the report, with the exception of the Intensive Care Bed Study, was relatively soft and based on the personal experience of the members of the committee.

The major projection is of a slow increase in the demand for intensive care beds in all units throughout the province. This will occur in parallel with an increase in the acuity of all in-hospital patients both in community and tertiary care hospitals. It is difficult because there is just no data to make any projection of the exact number of beds that will be required in five years, ten years and fifteen years.

The second projection is of a continuation of the chronic shortage of trained intensive care nurses in the province. This will effect some hospitals more than others, depending upon how attractive they can make working conditions.

The third projection is of a shortage of medical manpower throughout the province, particularly in the north and at the tertiary care hospitals in Winnipeg.

More optimistically, it is likely that the current difficulties with transportation and co-ordination of evacuations will improve, given efforts in this area.

RECOMMENDATIONS

Bed Capacity

It appears that current intensive care bed capacity, particularly in the City of Winnipeg, is not adequate to meet existing demands. This capacity should be increased in the short term by:

(a) efforts to recruit adequate numbers of intensive care nurses;

(b) an increase in funded positions for intensive care nurses;

(c) implementation of funding for Hospital Medical Officers.

In the longer term it will be necessary to open more intensive care beds in Winnipeg and probably Brandon. St. Boniface General Hospital has a major increase in beds planned. The Health Sciences Centre HA development plan, currently in hybernation, called for a similar major increase in critical care beds. These increases should be adequate to handle demands at the tertiary care hospitals. At the community hospitals the current beds are likely to be adequate in the short term if blocked beds can be elminated. In the longer term, as the community hospitals increase the acuity of their patients, some increase in bed capacity may be necessary at the Grace, Victoria and Seven Oaks. Adequate physical capacity apparently exists at Concordia and Misericordia Hospitals.

INTERMEDIARY CARE

The province has a choice in determining the relative course of intensive care over the next decade. If the current two level system of intensive care, averaging 18 to 28 nursing hours per patient, and ward care averaging 3 to 5 nursing hours per patient, continues, increased general ward patient occupancy will evitably lead to a much greater demand for intensive care beds. Since intensive care patients automatically get 18 to 28 nursing hours of care this will be a more expensive solution to the acuity problem. A less expensive solution will be development of intermediary care, high dependency or step-down beds. Such beds will provide for the more seriously ill of the ward patients without occupying intensive care beds. Such arrangements are already occurring in the development of cardiac telemetry (Appendix E) and neurosurgery and cardiac surgery step-down areas. Expansion of these facilities and development of step-down areas in relation to medical, surgical and pediatric wards will be required.

QUALIFICATIONS

It is recommended that the College of Physicians and Surgeons of Manitoba and the Manitoba Association of Registered Nurses develop appropriate qualifications criteria for both medical and nursing personnel working in intensive care areas in rural and northern areas. Such qualifications criteria should be realistic.

TRANSPORT

It is recommended that the Manitoba Health Services Commission move as rapidly as possible to implement the recommendation of the College of Physicians and Surgeons of Manitoba report on Transport and Northern Medical Services.

B.W. KIRK, M.D.
May, 1985

HEALTH SERVICES REVIEW

SUBCOMMITTEE ON HEALTH SERVICES TO THE ELDERLY

MAY 1985

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I. MEMBERSHIP

Joel S. Hurwitz, M.B. Chairman	Head, Department of Geriatric Medicine Seven Oaks General Hospital
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Edward Gelhorn	Administrator Luther Home
Eckhard Goerz	Program Specialist Continuing Care Directorate
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Kay Thomson	Director Long Term Care Programs Division Manitoba Health Services Commission
Brian Woods	Assistant Executive Director Seven Oaks General Hospital

II. CHAIRMAN'S REMARKS & ACKNOWLEDGEMENTS

The subcommittee membership was deliberatly chosen to represent a very broad discipline/professional background, with a balance between program and policy planners and those providing direct care. Our initial thrust was aimed at identifying the bottlenecks, areas of duplication and gaps, within the current health care system for the elderly. Arising out of subsequent discussion, we have formulated recommendations which, in our opinion, would increase the effectiveness of current health care dollars, faced with the realities of fiscal restraint.

Although overall cost savings are not identified, this subcommittee believes that **allocation of a greater percentage of current finances/resources into the community sector, can lead to savings (and certainly reduced cost escalation) in the highly expensive institutional sector.** As such, we would agree with the recent Task Force on the Allocation of Health Care Resources, who have stated "the thrust in the redirection of health care resources undeniably needs to be in the development of community services to keep the elderly out of institutions for as long as possible, not only to reduce costs, but to enhance the quality of life".

If we are serious about reducing institutional costs, then certain steps have to be taken. Hospitals of all types must recognize the unique needs of the ill elderly, and move to meet this challenge by improving their own clinical resources for this subgroup. In addition, though an absolute freeze on personal care home bed construction is not advocated, nevertheless any further expansion must occur in a controlled fashion. This would include monitoring the rate of institutionalization of the elderly (currently 6.9 percent for long-term institutionalization -- see Appendix C), re-examining personal care home admission criteria, and ensuring that these criteria continue to be consistently applied only after appropriate assessment, and all viable alternatives within the community have been explored.

Our concensus is that the major programs and resource expertise for the elderly are available in Manitoba. However, we are very concerned that many of our elderly fare badly, because their real health needs fall between the program mandates and jurisdictional boundaries of many government departments. To ensure optimal service provision where it is really needed, this subcommittee feels strongly, that greater coordination and communication is required between the involved government departments. One model for re-organization under a single department is presented.

Consistently identified as a deficiency in the Services/Care/Treatment continuum (Appendix E) was in the area of supported independence. Too few living alternatives are available between independent versus institutional living. Supported independence, both within elderly persons housing (E.P.H.) and residential care, requires expansion.

As a society, we have to decide what level of care for the elderly (as for any other population group) we are willing to provide. Unless resources are unlimited, this will require decisions based on fair priorization, and the flexibility and cooperation to permit appropriate and acceptable risk-taking.

Demographic projections clearly indicate that our Province and country is rapidly aging. Even the minor concerns of today will quickly assume major proportions, and hence there is considerable urgency to address these issues now.

Though this subcommittee worked energetically and met as a full group on nine occasions between August and December, 1984, a number of constraints are acknowledged. We individually solicited the viewpoints of many others, though time did not permit us to seek formal submissions from specific groups and organizations. At all times we attempted to tackle constructively the challenge presented to us, relying on our own perspective rather than that of the organizations within which we might function. Certain issues were cited which clearly require further review. In addition other key issues are acknowledged, but due to priorities set and time constraints, we agreed to defer detailed discussion as they had been dealt with elsewhere. For example: Psychogeriatrics, Elder Abuse, and the Young Adult Disabled.

J. S. Hurwitz

Joel S. Hurwitz

Acknowledgements: I would express my gratitude to all members of this subcommittee, for their enthusiasm and dedication to this task. Special praise must go to Linda Bakken who functioned not only as recording secretary, but contributed actively to this report. Finally, my thanks to Donalda Walker and Cindy Little at M.H.S.C. for typing the various drafts of this report.

III. TERMS OF REFERENCE

When the Minister of Health established the Health Services Review Committee and its sixteen subcommittees, terms of reference common to all subcommittees were established. The subcommittee on health services to the elderly, modified these terms of reference to reflect the complexity of services to the elderly beyond clinical and hospital based issues and programs. The Subcommittee on Health Services to the Elderly believes that the intent of the original terms of reference has been retained as reflected in the substance of the recommendations.

The redrafted Terms of Reference are as follows:

> The aging nature of our society, and the effect of an aging society on the use of and cost of health services forces the Province and its care providers to address methods of delivering a high quality of service without undo escalation of costs. The Subcommittee will review existing programs and delivery systems and make recommendations which can contain health care expenditures while maintaining a high quality system of care.

IV. LISTING OF RECOMMENDATIONS (Recommendations that are considered most essential appear in darkened type)

A. GENERAL AND SYSTEM RELATED ISSUES

1) **That Government proceed expeditiously to consolidate the planning, resource priority setting and allocation of existing and future services for the elderly under one department of government.**

2) That all undergraduate students from the health and social service field, should receive instruction on both normal and abnormal aging, as well as an introduction to the health care delivery system. Practice opportunities should be developed in order to encourage a positive interest in working in this area.

3) That clear guidelines must be established to guide the use of new and existing high technology diagnostic tests. Existing tests should be reviewed and evaluated and new tests should be subject to a stringent review process before they are incorporated into routine procedures.

4) That all proposals for new programs must include a plan which evaluates the impact of the program on the patient and on the health care system. A plan for the evaluation of existing programs should be developed by all major funding and service institutions. Funding for program evaluation must be recognized as integral to funding of programs by the Manitoba Health Services Commission.

5) That guidelines which include "Quality of Life" measures must be incorporated into assessments which lead to life saving decisions; e.g., renal dialysis and resuscitation by emergency teams in acute care hospitals. This is especially important for the "old old", or those with dementing illnesses and overwhelming diseases.

6) That health care professionals should routinely assess and discuss relevant risk factors with clients/patients, family members and/or significant others. Furthermore, where there exists uncertainty about the potential of the individual, a trial period involving "appropriate and acceptable risk" should be permitted before decisions are made regarding long term institutional placement.

7) That physician fee tariffs should be adjusted to recognize necessary medical services for the elderly, that are uniquely different and more time consuming from the rest of the adult population.

8) That all hospitals in conjunction with the Manitoba Health Services Commission should review their allocation and service distribution of beds, paying particular attention to the incidence/prevalence of disease and the age structure of the population that they serve.

B. ISSUES IN INSTITUTIONAL BASED SERVICES

9) **That considering the legitimate health needs of an aging society and their utilization of hospital services, it is recommended that all hospitals develop specific strategies to improve their own clinical resources for elderly patients and include mechanisms for linkage with appropriate community resources.**

10) That hospital based services with a focus on services to the elderly, should be regionally available throughout Winnipeg and in rural Manitoba. Such programming may occur within Extended Treatment Units, Geriatric Assessment Units or Departments of Geriatric Medicine, and should have clinical direction from Geriatricians, either within the same facility or easy commutable distance. Links and backup resources between Winnipeg and both Rural and Northern communities must be established.

11) **That there be optimal use of geriatric assessment and consultation (not necessarily requiring inpatient status) in order to obtain complete assessment of individual needs, guide subsequent management and reduce inappropriate use of institutional resources.**

12) That the routine involvement of physicians on personal care home assessment panels throughout the Province is supported. These physicians should be geriatricians or at least physicians with major experience/interest with the elderly.

13) **That the rate of institutionalization of the elderly must be closely monitored. The demand for personal care home services can be reduced by targeting new resources at supported independence and supporting caring families.**

14) That the current plan by M.H.S.C. to phase out, or upgrade where possible, hostel facilities is supported as a priority for implementation.

what does this mean? //

O

15) That the current personal care home bed planning guideline should be re-examined. Development of a new guideline should include an age and sex adjustment factor.

16) That current policies and procedures for admission to a personal care home should be revised to accommodate discharge from personal care homes (application form, residential charge and extended leave policy).

17) That personal care home admission criteria and the panel process must be examined regularly, and audit procedures should be developed and instituted.

18) That respite care resources, should be expanded throughout the province. Expansion will accommodate more flexible scheduling and more immediate access.

19) That a protocol should be developed for the transfer of social crisis admissions from hospitals to more appropriate locations; e.g., personal care homes or residential care facilities.

20) That one or two regions should be selected in which the respite care program should be publicized. The effects of increased public awareness of services to support families before a crisis develops, should be monitored. If such a program results in decreased use of other institutional and medical services, then consideration should be given to advertising the program on a larger scale.

21) That the Manitoba Health Services Commission should develop and monitor a policy for geriatric day hospitals which promotes their intensive, short term, assessment, rehabilitation and treatment capacities.

22) That the current geriatric day hospital capacity in Winnipeg is sufficient. Should a reduction in the present capacity occur, this must be paralleled by concurrent development of alternative more appropriate and less expensive programs (e.g. generic and specialized Adult Day Care).

23) That the Manitoba Health Services Commission should develop a policy for day hospital development in rural Manitoba. The model should address the unique needs and opportunities of rural Manitoba.

C. ISSUES IN COMMUNITY BASED CARE SERVICES

24) **That the Department of Health allocate sufficient resources to enable the Continuing Care Program to fulfill its existing mandate in light of increasing workload, both in terms of numbers and complexity. A staffing to workload ratio should be established along with mechanisms that ensure minimum staffing is guaranteed at all times for the coordination and delivery of service.**

25) That the Manitoba Health Services Commission and Office of Continuing Care continue their joint planning to ensure that hospital facility back-up is available to support heavier care in the community. Both hospital and community care programs must recognize their mutual resource dependency. However joint planning is ineffective unless the funding parameters support this planning.

26) That special funding be designated to the Office of Continuing Care to undertake and evaluate a series of demonstration projects to test alternative delivery models for the provision of heavier and/or special type treatment. Included might be a model of service delivery designed to respond quickly in non-medical emergency or crisis situations thereby preventing hospital admission.

27) That the Department of Health continue its commitment to provide leadership and funding for the development of basic community support services to sustain and enhance the health of the "well elderly" in order to offset the premature entry of persons into the health care system.

28) That the Province should continue a planned expansion of the adult day care resource, paying particular attention to the areas of the province not now served as well as special needs programs; e.g., for the cognitively impaired and younger disabled adult. Free standing or non-institutional locations and sponsors are required.

29) That expansion of Adult Day Care as a resource to the Continuing Care Program requires a reduction of the caseload ratio for case coordinators and an immediate response to filling staff vacancies occurring through attrition.

D. ISSUES IN COMMUNITY SUPPORT SERVICES

30) That all elderly persons housing authorities and boards be required to develop a capacity to respond to the support needs of their frailer tenants. Many of the support programs may need government funding assistance, but these could be supplemented by user fees, and local community contributions.

31) That such supports offered to the elderly living in seniors housing, be made available to similar persons who wish to reside in their own homes.

32) That for the 'high risk' elderly who wish to retain their independence, there should be a specialized form of housing, where programs, meals, and personal assistance are available on a 24 hour basis. Such accommodation should include wheelchair accessible and adapted units, and could utilize shared staff where there is juxtaposition or proximity to another facility; e.g., a personal care home.

33) **That the province of Manitoba should establish a Working Group to study the range of housing options that are required to develop a housing continuum. The Working Group should include representatives from the Departments of Health, Housing and Community Services.**

34) That the direction government is currently taking on the Support Services to Seniors policy is supported.

35) That Manitoba Housing and the Canadian Mortgage and Housing Corporation should adopt a proactive planning and resource allocation approach. Such planning should include consultation with Manitoba Health Services Commission and the Department of Health Regional Offices.

what does this mean w.r. present pop?

36) That where the density of seniors in the population is high, (20% of the population 60+ and/or numbers are substantial) a Senior Centre should be established to provide socializing opportunities and services to meet the needs and enhance the quality of the lives of the elderly population in the community.

37) That in areas where there are not currently health promotion programs which incorporate surveillance of the frail and at risk elderly, Senior Centres should be requested to perform this function.

38) That implementation of government policy on multipurpose Senior Centres will require the establishment of a pool of capital resources for construction and renovation of Senior Centres. Such capital should only be available to Centres that agree to meet C.I.S.C. standards. The highest degree of accessibility to the total aging community can be achieved if the Centres are free standing in visible locations rather than co-located in Elderly Persons Housing buildings.

V. MAJOR ISSUES AND RECOMMENDATIONS

A. GENERAL AND SYSTEM RELATED ISSUES

The following section addresses issues which affect the entire spectrum of care and services to the elderly.

1. Organization of Government Services

The Committee acknowledges the leadership position of the Province of Manitoba in the field of gerontology and geriatrics and recognizes the advanced level of service being provided to our senior citizens. While the needs of our elderly have been generally well served by a wide range of care providers and social agencies, the Committee has some concern about the ability of the current administrative structures to deal effectively with future demands for service.

The problems of addressing an aging population are complex. Many Manitoba Government Departments address this complex issue and develop programs aimed at specific needs. Manitoba Housing funds and sponsors housing units; Highways has launched the Rural Transportation Assistance Program; Health funds hospitals and personal care homes and delivers direct service through Continuing Care and Services to Seniors; Community Services and Corrections and the Departments of Education, and Economic Security & Employment Services are all involved in some manner with Manitobans over age 65. Appendix A attempts to list the major departments and programs that have immediate effect on the nature and the cost of health care.

The Subcommittee was frustrated by the numerous jurisdictional boundaries and complex vertical program mandates of departments, divisions and programs that relate to services for the elderly. In the subcommittee's view, vertical program separation leads to inappropriate resource allocation decisions and a chronic inability to plan and deliver services at the community level.

The subcommittee feels that a single authority for services specific to the elderly is required to effect the decision making necessary to reflect a true continuum of care and services.

It is the primary interest of this subcommittee that the people of Manitoba continue to be served as effectively as in the past. It is important for the Province to prepare now to meet the rapidly growing demands of our aging population for an increasingly complex array of services. The reorganization of government services can facilitate resolution of this problem.

In contemplation of alternate organizational arrangements, it is felt that the following criteria must be satisfied:

1) Service must be delivered in a cost effective and efficient manner;
2) The system must be responsive to the needs of our elderly; and facilitate priority setting and resource allocation within the total continuum of care and service;
3) Responsibility and accountability for service delivery in the civil service and non-government agencies must be visible, clear and unequivocal;
4) The organizational structure must facilitate effective interdepartmental and intradepartmental communications;
5) Fragmentation, gaps and overlaps in service must be minimized; and
6) Community groups must have access to health care system planners in order to facilitate planning and resource allocation at the community level.

The Committee recognizes that it may be difficult to structure a large organization to incorporate all of these criteria, but we believe these criteria may be helpful in mapping out a plan for the future. Of course, organizational changes alone will not assure success; they must also be matched with sufficient resources administered with prudence and foresight.

Recommendations:

1) That Government proceed expeditiously to consolidate the planning, resource priority setting and allocation of existing and future services for the elderly under one department of government (see Appendix B).

2. Education of Health Professionals

Background:

Numerous categories of health professionals are involved in the wide range of health and social services for elderly people. The practice of "multidisciplinary teams" and the "continuum of care" concept are key elements to the way the full cadre of health workers practise their profession with the elderly. The need for health services by an aging population places a high demand for new graduates in all professions to look at a career with the elderly in positive and challenging terms.

Issues:

The curriculum for all health professionals at the undergraduate, and graduate level does not generally reflect the age structure of the population, the incidence of morbidity or the pattern of utilization of health services. Many of the major schools training health professionals do not have faculty members with specific expertise in and commitment to geriatrics.

Few if any curricula instruct students on the health care delivery system or on the role of their profession in the care of the elderly. This produces myopic graduates whose work experience may contribute to the singular view of care and treatment.

Recommendations:

2) That all undergraduate students from the health and social service field, should receive instruction on both normal and abnormal aging, as well as an introduction to the health care delivery system. Practice opportunities should be developed in order to encourage a positive interest in working in this area.

3. Evaluation

Background:

Within the health care system, there exists a particularly wide range in the quantity and quality of the analysis and evaluation of programs and services. Traditionally, the acute care institutions have had well developed mechanisms; e.g., peer review, medical audit, accreditation surveys, etc. However, other parts of the system have been almost totally void of any structured evaluation.

Issues (Issues 1 & 2 are equally applicable to all age groups):

1. High Technology

The cost of increasing use of high technology contributes to the escalation of health costs without a corresponding effect on morbidity and mortality rates. Factors which have produced this situation include public expectations, the practise of "defensive medicine" and increased reliance on specialists and diagnostic tests. Many "high tech" procedures have become routine and acceptable practices causing inflationary health costs without appropriate evaluation of their efficacy, effectiveness, efficiency and availability.

2. Program Evaluation

New program thrusts are often perceived as the salvation to many specific problems, yet program evaluation has not received sufficient attention or resources. New and existing programs must be evaluated both for their effect on the health care system and their impact on the person.

3. Traditionally, the major over-riding goal of the health care system has been the protection, preservation and prolongation of life at all costs. While this goal should continue to guide decisions, it is essential that an assessment of the quality of life receive adequate consideration.

Recommendations:

3) That clear guidelines must be established to guide the use of new and existing high technology diagnostic tests. Existing tests should be reviewed and evaluated and new tests should be subject to a stringent review process before they are incorporated into routine procedures.

4) That all proposals for new programs must include a plan which evaluates the impact of the program on the patient and on the health care system. A plan for the evaluation of existing programs should be developed by all major funding and service institutions. Funding for program evaluation must be recognized as integral to funding of programs by the Manitoba Health Services Commission.

5) That guidelines which include "Quality of Life" measures must be incorporated into assessments which lead to life saving decisions; e.g., renal dialysis and resuscitation by emergency teams in acute care hospitals. This is especially important for the "old old", or those with dementing illnesses and overwhelming diseases.

4. Risk Taking

Background:

One of the major issues relating to the elderly, and one that so often leads to at least a perceived need for alternative and "safer" placement, is the element of **risk**.

Risk is not a unique gerontological phenomenon. Conversely, risk is with all of us every day of our lives. Facing even the healthy young adult is the risk of a motor vehicle accident and the risk of becoming ill, etc. Removing all risk from our lives would be as undesirable as removing all stress. Indeed, our health depends on some degree of risk and stress, to provide the challenge, choice and motivation for optimal life satisfaction.

To "wrap old people in cotton wool" and to respond to risk with the knee jerk reaction of institutional placement, is both a denial of individual rights as well as a financial hardship to any society.

Issues:

All participants in the health care system in Manitoba, the professionals, the client/patient, the family and the public should weigh their motivations for institutionalizing the elderly against the personal and economic costs of such decisions. The following issues should be included in the debate regarding appropriate risk taking with the elderly.

1) For the competent older adult, it is more important to assess risk as perceived by that individual, rather than by concerned others; e.g., family members, neighbours, health care professionals, etc.

2) As well as subjective impressions, an attempt should be made to measure individual risk objectively; e.g., the number of occurrences and their seriousness.

3) The underlying factors leading to an "at risk" situation need to be identified as clearly as possible. Only then can possible corrective steps be explored; e.g., the use of appropriate drugs to prevent heart irregularities which resulted in recurrent falls/faints.

4) Where the degree of risk associated with community living is unknown or uncertain, the health care team, family and patient should be encouraged to try the community living option. In this situation, appropriate community supports must be put in place and alternate or back-up resources must be assured. A spirit of genuine cooperation and flexibility between involved parties is essential.

5) The factors which foster the current protective attitudes will require examination, as well as the necessary legal changes essential to support increased risk taking.

Recommendations:

6) That health care professionals should routinely assess and discuss relevant risk factors with clients/patients, family members and/or significant others. Furthermore, where there exists uncertainty about the potential of the individual, a trial period involving "appropriate and acceptable risk" should be permitted before decisions are made regarding long term institutional placement.

5. Physician Remuneration

Two key physician issues relative to an aging population are: Education and Recruitment: the education of all physicians to a greater or lesser extent, depending on their practice profile and speciality; the recruitment of a cadre of physician specialists to provide the academic and service leadership in the field of aging.

A third issue perceived to be of utmost importance and to be addressed here, is that of Physician Remuneration. The current fee for service system tends to reward well for 'procedural' and 'high volume' medicine.

The elderly person with legitimate health problems, who presents to his/her physician will often do so with vague and insidious symptoms, complex associated psychosocial factors, as well as multiple pathologies and medications. This means that history taking and examination, as well as proper medical evaluation simply takes longer. Necessary explanations to achieve the patient's full understanding and thereafter cooperation in the care program are needed, and usually take more time than with the non-aged sick person.

This uniqueness is well recognized in other countries and with other systems for medical remuneration. For example: A higher per capita fee for elderly patients, provided to family physicians in the United Kingdom. In addition there are other essential services such as counselling and preventive care, for which the current fee schedule acts as a practice disincentive.

Recommendation:

7) That physician fee tariffs should be adjusted to recognize necessary medical services for the elderly, that are uniquely different and more time consuming from the rest of the adult population.

6. Hospital Organization and Management

Background:

The present system of hospital organization and management has not kept pace with the increasing demands for health care by the elderly population. This is primarily apparent in the allocation of beds within secondary and tertiary care hospitals. The division and protection of beds by the main medical disciplines of medicine, surgery, obstetrics and gynecology, pediatrics, psychiatry, etc., does not reflect patient flow into the hospital, nor the health care needs of the population.

Issues:

Hospital bed allocation often relates to the needs of physicians and their power within the hospital structure. For example, surgical beds, their allocation and utilization, may reflect internal hospital dynamics rather than patient need.

The needs of the elderly are often in conflict with the needs of the physician whose financial position requires rapid patient turnover, and reduced average duration of stay. Assessment, diagnosis, treatment, rehabilitation and recovery in elderly people generally takes longer than in those under 65.

Elderly patients are often viewed as bed blockers, inappropriate or undeserving users of resources that could be used more appropriately.

Recommendations:

8) That all hospitals in conjunction with the Manitoba Health Services Commission should review their allocation and service distribution of beds, paying particular attention to the incidence/prevalence of disease and the age structure of the population that they serve.

B. ISSUES IN INSTITUTIONAL BASED SERVICES

Introduction

The recent Task Force on the Allocation of Health Care Resources commissioned by the Canadian Medical Association investigated the impact of demographic change on the health care system in Canada.

Of several scenarios tested, by far and away the greatest financial savings occurred as a result of reducing institutionalization of the elderly (in hospital, long term care and mental health facilities) from the current level of 9.45 % to 6.00 %. The projected savings for Canada as a whole, were 22.2 Billion dollars for annual operating and accumulative capital construction costs between 1981 and 2021. To put this in perspective, between the years 1981 and 2021, demographic changes alone (excluding inflationary factors) will increase expenditures on health care by about 75% - if current patterns of providing care remain unchanged. This same Task Force concluded that the one growth area necessary to redirect this pattern would be in the area of Home Care services, where accelerated growth (seven-fold) would have to occur to allow a reduction in institutionalization of the elderly.

A joint Ministerial Task Force[1] for the Province of Saskatchewan recommended that a target of 5% institutionalization amoung the elderly, should be set. The decrease suggested was through attrition from the lower levels of nursing care beds.

As of November 1984, the rate of institutionalization among the elderly of Manitoba was 6.90%. (See Appendix C) This number excludes those elderly living at home who are panelled and awaiting personal care home placement.

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[1] Report of the Joint Ministerial Task Force on Services for Senior Citizens in Saskatoon and Rural Community - August 1978.

1. Hospital Sector

Background:

Although it is one component of the health service continuum, the hospital sector has traditionally received emphasis and currently accounts for 53.9% of Health expenditures (M.H.S.C. and Department of Health expenditures - 1983/84 approved).

Within Manitoba, hospital beds are classified as either Active Treatment or Extended Treatment. Including all types of hospital beds, the Manitoba ratio is identical to that of Canada as a whole; i.e., 6.8 hospital beds per 100,000 population.

In recent years, structured hospital based programming for the elderly in Manitoba has tended to occur within the extended treatment sector. Program components for Extended Treatment have been defined.[2]

Within the last decade, certain of the Extended Treatment facilities have further developed specific Departments of Geriatric Medicine with a clear commitment to the elderly. In addition to assessment, rehabilitation and long term care responsibilities, they have taken on Crisis Intervention, active Community Outreach and in some situations the management of acute clinical problems in the elderly. An alternative or additional model is the Geriatric Assessment Unit (G.A.U.), most usually existing as a 10-20 bed specialized unit within an active treatment facility.

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[2] See Appendix D for 1984 approved definitions of Extended Treatment program components - August 1984.

Issues:

a) The "Geriatric Bed Blocker"

There is a widely held misconception, both among health care professionals and society as a whole, that the elderly are a 'block' to efficient bed usage and turnover in hospitals.

Certainly within our aging society, the elderly use a very high proportion of hospital days. For Canada in 1977, 9% of the population (those aged 65 and over) consumed 43% of all acute hospital days. (Stats Canada 1980) The pattern is very similar within the Province of Manitoba. Hospital usage also rises dramatically with age. The 85 and over group consume approximately 10 times as many hospital days as any of the age groups under 60. However, as Roos and Shapiro[3] clearly show, most of the elderly are healthy and are in fact low and in-frequent users of hospital service:

- on a per capita basis in Manitoba , less than 1/4 of the elderly are hospitalized any given year.
- 42% of the elderly were not hospitalized over a 5 year period.
- further examination revealed that a small subgroup (2%) of the elderly are consuming a disproportionately large proportion (20%) of the total days utilized by the elderly.

The issue is however, that the myth of 'geriatric bed blocking' results in negative stereotyping of the elderly. As a result, their hospital needs do not receive a high priority and aspects of their complete assessment, and treatment are delivered without therapeutic optimism. This can only be rectified through a greater education of hospital staff in the areas of geriatrics and geriatric medicine.

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[3] Roos and Shapiro 'Aging and the Demand for Health Services', The Gerontologist - Volume 24, No. 1, 1984.

b) Geriatric Expertise and the Continuum of Care Within the Hospital Sector

Geriatric expertise and specific hospital based program components for the elderly have a relatively short history in Manitoba. However it is the opinion of the subcommittee that this level of expertise and focus provides cost effective, humane, holistic and appropriate service.

A study published in the New England Journal of Medicine (Dec. 27, 1984) concluded "that geriatric evaluation units can provide substantial benefits at minimal cost for appropriate groups of elderly patients, over and above the benefits of traditional hospital approaches."[4] Patients assigned to the geriatric unit had much lower mortality, were less likely to have been initially discharged to a nursing home, were more likely to have improvement in functional status and morale and the health system experienced lower direct costs for institutional care.

These findings from one component within the geriatric service continuum are appropriate health care system objectives for Manitoba and can be achieved through recognition and support of the value of geriatric medicine and its accompanying program and organizational supports.

To be effective, geriatric services require a range of service options, each geared to maximize independent functioning and reduce reliance on institutional care. The range of service options include: designated and protected assessment resources, intensive rehabilitation resources (both on an inpatient and day basis), strong and supportive links with community based services, access to social crises or respite beds and supportive housing environments.

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[4] Rubenstein, L.Z.; Josephson, K.R.; et el "Effectiveness of a Geriatric Evaluation Unit"; The New England Journal of Medicine, Dec. 27, 1984.

Recommendations:

9) **That considering the legitimate health needs of an aging society and their utilization of hospital services, it is recommended that all hospitals develop specific strategies to improve their own clinical resources for elderly patients and include mechanisms for linkage with appropriate community resources.**

10) That hospital based services with a focus on services to the elderly, should be regionally available throughout Winnipeg and in rural Manitoba. Such programming may occur within Extended Treatment Units, Geriatric Assessment Units or Departments of Geriatric Medicine, and should have clinical direction from Geriatricians, either within the same facility or easy comutable distance. Links and backup resources between Winnipeg and both Rural and Northern communities must be established.

11) **That there be optimal use of geriatric assessment and consultation (not necessarily requiring inpatient status) in order to obtain complete assessment of individual needs, guide subsequent management and reduce inappropriate use of institutional resources.**

2. Personal Care Homes

Issues:

a) Availability of Personal Care Home Resources

The number and percent of elderly Manitobans living in institutions was of grave concern to the subcommittee. Appendix C shows that 6.9% of Manitobans over age 65 live in twenty-four hour care situations. There was a concensus that the institutionalization rate could be reduced (perhaps to between 5-6%) and must be controlled over time with an infusion of resources to support community living. These resources should be targeted to support independence of the elderly persons and support the caring family.

b) Hostel Accommodation - Level I

The current personal care home bed guideline and the continued inclusion of level I care in the insured personal care home program was the subject of much discussion by the subcommittee. Consensus on Level I care as an insured health service was not achieved. There was a strong minority position that level one care was a social program not a health service and should be removed as an insured benefit.

c) Personal Care Home - Bed Planning Guideline

The present personal care home bed ratio in Manitoba is 93.56 beds/1000 population age 70+, while the guideline is 90/1000. While the current situation exceeds the guideline, the guideline does not reflect the average age of entry to personal care homes (83) nor the effect of the younger disabled adult whose average length of stay is much longer than the older resident.

d) Discharge from Personal Care Homes

There is a prevailing attitude when an individual is panelled for, or enters a personal care home, that the individual will never return to the community again. Their home and furniture is disposed of, and the personal care home is viewed as a point of no return.

This prevailing public attitude to personal care home placement needs to be changed, as some individuals have the potential for improvement and could function once again in the community. Although it is recognized that this number may be small, nevertheless a mechanism with the appropriate policies, should be put in place to facilitate discharge.

e) Panel Process for Personal Care Home Admission

The panel process for admission to a personal care home is the gate keeper to the most expensive resource in the continuum of long term care both in terms of loss of personal freedom and cost. This process needs to be audited on a regular basis and evaluated on a regular basis to ensure that its major and pivotal role in the system is effective, efficient and appropriate.

Recommendations:

12) That the routine involvement of physicians on personal care home assessment panels throughout the Province is supported. These physicians should be geriatricians or at least physicians with major experience/interest with the elderly.

13) That the rate of institutionalization of the elderly must be closely monitored. The demand for personal care home services can be reduced by targeting new resources at supported independence and supporting caring families.

14) That the current plan by M.H.S.C. to phase out, or upgrade where possible, hostel facilities is supported as a priority for implementation.

15) That the current personal care home bed planning guideline should be re-examined. Development of a new guideline should include an age and sex adjustment factor.

16) That current policies and procedures for admission to a personal care home should be revised to accommodate discharge from personal care homes (application form, residential charge and extended leave policy).

17) That the criteria for admission and the panel process to a personal care home must be examined regularly, and audit procedures should be developed and instituted.

3. Respite Care in Personal Care Homes Program

Background:

There is a need for greater opportunities to provide care providers with relief at an earlier stage so that they can continue to support their relatives in the community longer or indefinitely. The present system for identifying these support needs may not be adequate as it relies, for the most part, on the individual being known to the Continuing Care program.

Issues:

There has been a reluctance to advertise the program for fear that the demand might be too great to handle. On the other hand it is much easier to plan appropriate resources when the need is known. Intervention and support can then be facilitated at more appropriate times.

Current respite resources are inadequate, particularly outside Winnipeg. The lack of appropriate respite resources has also produced a rather rigid schedule for its use; i.e., individuals are generally admitted for a minimum of 2 weeks (1 week respite is available by special request). Respite Care, to serve its true purpose requires far more flexibility; i.e., evening care, weekend care, 3 and 4 day rotations, etc. Sufficient respite resources are required to allow for the flexibility of accommodating individual needs.

Several care providers have expressed the need for a number of beds to be designated for "crisis" admissions. These are primarily social in nature, and it is felt they could be provided for outside a hospital setting, if they were able to be accessible at short notice.

Recommendations:

18) That respite care resources, should be expanded throughout the province. Expansion will accommodate more flexible scheduling and more immediate access.

19) That a protocol should be developed for the transfer of social crisis admissions from hospitals to more appropriate locations; e.g., personal care homes or residential care facilities.

20) That one or two regions should be selected in which the respite care program should be publicized. The effects of increased public awareness of services to support families before a crisis develops, should be monitored. If such a program results in decreased use of other institutional and medical services, then consideration should be given to advertising the program on a larger scale.

Issues:

1) Definition and Objective

The admission criteria, average length of stay, staffing patterns and programs in the 6 Manitoba sites vary.

The day hospital is an important resource, its role in the continuum is well documented and supported; day hospitals provide a distinctive service which must be protected through its ability to refer and discharge patients to other appropriate resources. This subcommittee supports the Federal guideline on Geriatric Day Hospitals and recommends tighter adherence to the definition through admission and discharge criteria; i.e., the length of stay for the majority of patients should not exceed 15 weeks, the patient should require 2 or more services and discharge should occur when assessment is completed or the rehabilitation and treatment potential has been realized.

2) Rural Elderly

The needs of rural elderly are similar to those living in urban areas. While extended treatment units exist in Steinbach, Portage, Dauphin and Morden, the functions available in an urban day hospital are occurring on an inpatient basis. While the geographic distribution of the elderly and the inherent transportation problems make it inappropriate to transfer an urban day hospital model to rural Manitoba, distinctively rural models should be developed to encourage assessment, rehabilitation and treatment on a day basis where appropriate.

3) Provincial Day Hospital Capacity

Manitoba's present and future capacity in geriatric day hospital could be redistributed and possibly reduced if tighter criteria on program and admission and discharge criteria were put in place. However, redistribution of present or future day hospital capacity to Rural Manitoba or into specialized day hospitals cannot be undertaken unless the appropriate alternatives for existing patients are put in place and the appropriate linkages are established. These may include referral to home care, additional or specialized Adult Day Care and resources to bridge the transition to Senior Centres or other mainstream supports.

4) Assessment Capacity

Geriatric Day Hospitals provide some of the most comprehensive and specialized geriatric assessment expertise available to Manitobans (mostly Winnipegers). This assessment capacity should be fully and freely available to the Continuing Care Program and primary care physicians.

Recommendations:

21) That the Manitoba Health Services Commission should develop and monitor a policy for geriatric day hospitals which promotes their intensive, short term, assessment, rehabilitation and treatment capacities.

22) That the current geriatric day hospital capacity in Winnipeg is sufficient. Should a reduction in the present capacity occur, this must be paralleled by concurrent development of alternative more appropriate and less expensive programs (e.g. generic and specialized Adult Day Care).

23) That the Manitoba Health Services Commission should develop a policy for day hospital development in rural Manitoba. The model should address the unique needs and opportunities of rural Manitoba.

C. ISSUES IN COMMUNITY BASED SERVICES

1. Continuing Care/Home Care

Background:

The Continuing Care Program, established in 1974, is a province-wide program designed to support the care of persons living in the community. The program provides both a broad range of care services to persons in their own homes and facilitates the placement of persons into personal care homes when care at home is no longer viable.

The program currently serves some 14,000 persons per month (September 1984) through a network of "coordinating agencies". The growth in caseloads in the 5 years preceding 1984 has been 43%. There has been no corresponding increase in staff during that time. The direct service costs associated with providing the care however have grown substantially (165%).

Current Program Trends:

a) There is an increasing number of those on the program requiring heavier service and more instensive staff tme. This applies to the elderly, the terminally ill and the younger disabled.

b) The over age 80 population is the greatest user of the Continuing Care program and this is the portion of the population that is experiencing the most rapid increase in number and percent.

c) There is a growing demand for heavier and more complex care in the community. Some types of care requested exceed current capacity within the program.

d) The extension of new treatment and care techniques to the community (e.g. Central Venous Line/tube feeding) involve either increased dollar expenditures or intensive staff time or both.

Issues:

Given the above, it has become apparent that the resources allocated to care in the community are very inadequate. Information from the Continuing Care program indicates:

1) Critical staff shortages at all levels.

   i.e.: service delivery, program supervisory, resource management, and program planning and coordination. There are regional variations in these shortages with Winnipeg Region being most affected.

   Until an adequate level of staffing is in place there can be no controlled or efficient expansion of community care.

2) There is a need to improve the status and benefits of current direct service (non civil service - payroll) employees to facilitate adequate recruitment and assignment capability in relation to client needs.

3) There is a need to develop more effective means of program information management - specifically computerization. The existing manual system precludes efficient management of resources and future planning.

4) The Continuing Care program requires access to committed hospital backup (designated beds). The need for this resource is the result of two related but separate trends: a) the increasing number of people requiring 7 day a week service and support; and b) the increasing number of people for whom the only alternative resource is a hospital admission.

   The availability of a hospital back-up resource would require resolution of the staffing and resource issues noted above and the mandate to initiate demonstrations of some alternative delivery models.

5) There is a need to have a broad range of community based services for the well elderly developed further to keep them "well elderly" and prevent premature need for Home Care.

Recommendations:

24) **That the Department of Health allocate sufficient resources to enable the Continuing Care Program to fulfill its existing mandate in light of increasing workload, both in terms of numbers and complexity. A staffing to workload ratio should be established along with mechanisms that ensure minimum staffing is guaranteed at all times for the coordination and delivery of service.**

25) That the Manitoba Health Services Commission and Office of Continuing Care continue their joint planning to ensure that hospital facility back-up is available to support heavier care in the community. Both hospital and community care programs must recognize their mutual resource dependency. However joint planning is ineffective unless the funding parameters support this planning.

26) That special funding be designated to the Office of Continuing Care to undertake and evaluate a series of demonstration projects to test alternative delivery models for the provision of heavier and/or special type treatment. Included might be a model of service delivery designed to respond quickly in non-medical emergency or crisis situations thereby preventing hospital admission.

27) That the Department of Health continue its commitment to provide leadership and funding for the development of basic community support services to sustain and enhance the health of the "well elderly" in order to offset the premature entry of persons into the health care system.

2. Adult Day Care

Background:

The Adult Day Care Program has proven to be a valuable low cost resource in the continuum of care as well as providing a low cost and more appropriate substitute for hospital, medical care, and personal care home placement. The program addresses the debilitating effects of social isolation and provides respite for primary care providers.

Funding for this program has grown annually in response to increasing need and sponsor capacity. In the fiscal year 1984/85, $786,300 was allocated. This provides funding for 45 sponsors serving up to 700 individuals at any one time. However, not all communities are served; many programs have waiting lists and some special needs groups can not be served in the generic program.

Issues:

a) Program Expansion:

Continued expansion of this valuable resource to supported independence is dependent on two factors:

1) The stability in number and kind of continuing care case coordinators. The program is dependent on referrals from the Provincial Continuing Care Program. As the caseloads increase and staff vacancies are slow to be replaced, workers are unable to use and manage resources of this kind.

2) The program has been dependent on the ability of personal care homes to expand their services in the area of outreach. As some personal care homes are inappropriate, as some communities do not have a personal care home and, as some target groups find the personal care home ambiance a deterrant to participate, free standing or non-institutional sites and sponsors are required.

b) Special Needs Groups

Adult Day Care was designed to meet the needs of frail, at risk and cognitively competent seniors. However, the at risk home care client varies in age and cognitive ability. The target group requires expansion and the program design needs to be changed to accommodate these special needs groups.

Recommendations:

28) That the Province should continue a planned expansion of the adult day care resource, paying particular attention to the areas of the province not now served as well as special needs programs; e.g., for the cognitively impaired and younger disabled adult. Free standing or non-institutional locations and sponsors are required.

29) That expansion of Adult Day Care as a resource to the Continuing Care Program requires a reduction of the caseload ratio for case coordinators and an immediate response to filling staff vacancies occurring through attrition.

D. ISSUES IN COMMUNITY SUPPORT SERVICES

1. Housing and Support Services

Background:

Historically housing authorities have viewed their responsibility as being limited to providing safe and affordable shelter. With increasing age and frailty, elderly persons require better access to additional supports; e.g., meals, transportation, security, emergency call systems, assistance with shopping and household management, etc. to offset their move towards institutionalization. While all of these supports can and should be made available to the elderly living in their own homes, congregate elderly persons housing settings are a natural target for these additional services.

Issues:

Housing boards and managers need to expand their service value base beyond the current property management purview incorporating some of the principles of a social service agency. Housing, by the nature of its tenants has moved beyond the shelters model and therefore the board and management structure must be altered to reflect its new reality.
Housing options like the care system require a number of creative options in the continuum from total independence to supported independence. The present continuum includes: own home, elderly persons housing (E.P.H.), support service E.P.H., foster homes, residential care and personal care home. Additional options are required. Foster homes, communal living and cooperatives are examples of housing options which have not been given sufficient attention.

The absence of sufficient appropriate housing and of a sufficiently broad range of housing options contributes significantly to persons seeking admission to personal care homes, or in crisis situations, into hospitals. Conversely, the discharge from such facilities is hampered by the absence of appropriate housing and its attendant supports.

1.3 the medical advisor would recommend guidelines for the level of training of physicians, nurses, and pre-hospital care personnel

1.4 the medical advisor would develop protocols for the delivery of emergency health care on a provincial basis

1.5 the medical advisor would designate those communities served by the air ambulance and establish specific guidelines for the type of patients served by the air ambulance

2. Shortage of medical beds and proper utilization of hospital beds

2.1 each hospital should have a physician designated with the responsibility within a committee for admission and discharge planning for proper bed utilization

2.2 nursing home beds and the effect of insured services needs to be examined by personnel dealing with PCH. It was noted that 50% of the persons who entered PCH's July 1, 1973 are still in the PCH's

2.3 alternative forms of community health care for the elderly need to be examined

3. Shortage of sub-specialty hospital beds

3.1 Neuro surgery - neuro surgery bed shortages should be addressed by a special committee

3.2 Psychiatry - restructuring is needed so that there is one acute psychiatric unit in Winnipeg with referral from other hospitals. (It was noted that this was a minor problem)

3.3 the need for specialized training of nurses to deal with patients in psychiatric crises

3.4 Brandon and Selkirk Mental Health Centres require more psychiatrists

3.5 transportation personnel need to examine the problem of RCMP transport of psychiatric cases. RCMP stop at the perimeter highway

4. Operation of Emergency Rooms

4.1 establish an optional method of admission to hospital rather than through the emergency room

4.2 provide education to physicians and patients regarding proper utilization of emergency rooms

4.3 develop a better communication system amongst emergency rooms

...3

4.4 hospitals that are 60+ beds should have 24 hour in-hospital physician coverage in the emergency room

4.5 in those hospitals (60+ beds) with high patient flow from 1900 - 2400 hours, physicians should be remunerated as per the special visit fee schedule, and be given a sessional fee from 2400 - 0800 hours

4.6 in those hospitals (60+ beds) with low patient flow from 1900 - 2400 hours, physicians should be remunerated on a sessional fee basis from 1900 - 0700 hours

4.7 inadequacy of space and planning in emergency rooms needs to be addressed

4.8 no data was available on the effect of walk-in clinics and ENVOY on the delivery of emergency health care. Therefore, no recommendation could be made at this time

4.9 regionalization of multi trauma cases was discussed. The committee was not prepared to make a recommendation on the regionalization of multi trauma cases based on lack of data and incongruence if Winnipeg is compared to other cities

5. Physician and nurse training to work in emergency rooms

5.1 for 60+ bed hospitals physicians throughout the province should be encouraged to be trained in ACLS and ATLS

5.2 ATLS training be offered to physicians in undergraduate years (ACLS is already offered in this manner)

5.3 ACLS and ATLS training should be recommended/encouraged through CPS, MMA and the local board of the hospital

5.4 ACLS and ATLS training be provided to a core group of nurses in the city, rural areas, and nursing stations, focusing particularly on those areas where there is no 24 hour in-hospital physician coverage

5.5 nurses taking ACLS and ATLS courses should receive remuneration for taking the training

5.6 the problem of the mechanism of course delivery, and status of nurses receiving this training needs to be examined by nursing standards/education personnel

6. Ambulance services and pre-hospital care

6.1 it is imperative that the medical advisor for air and ground ambulance services be one and the same

6.2 the problem of "grey areas" in ambulance services needs to be examined. (eg. Sanford is serviced by the Carman ambulance, yet is closer to Winnipeg)

...4

Recommendations:

30) That all elderly persons housing authorities and boards be required to develop a capacity to respond to the support needs of their frailer tenants. Many of the support programs may need government funding assistance, but these could be supplemented by user fees, and local community contributions.

31) That such supports offered to the elderly living in seniors housing, be made available to similar persons who wish to reside in their own homes.

32) That for the 'high risk' elderly who wish to retain their independence, there should be a specialized form of housing, where programs, meals, and personal assistance are available on a 24 hour basis. Such accommodation should include wheelchair accessible and adapted units, and could utilize shared staff where there is juxtaposition or proximity to another facility; e.g., a personal care home.

33) That the province of Manitoba should establish a Working Group to study the range of housing options that are required to develop a housing continuum. The Working Group should include representatives from the Departments of Health, Housing and Community Services.

34) That the direction government is currently taking on the Support Services to Seniors policy is supported.

35) That Manitoba Housing and the Canadian Mortgage and Housing Corporation should adopt a proactive planning and resource allocation approach. Such planning should include consultation with Manitoba Health Services Commission and the Department of Health Regional Offices.

2. Senior Centres

Background:

A Senior Centre is a community focal point where older persons as individuals or in groups come together for services and activities which enhance their dignity, support their independence and encourage their involvement in and with the community.

As part of a comprehensive community strategy to meet the needs of older persons, senior centre programs take place within and emanate from a facility. These programs consist of services and activities in such areas as education, creative arts, recreation, advocacy, leadership development, employment, health, nutrition, social work and other supportive services.

The Centre also serves as a community resource for information on aging, for training professional and lay leadership and for developing new approaches to aging programs.

At the present time, Senior Centres are the only focal point for the elderly that offer both activities and services. The support services provided by a Senior Center are important to the well elderly if they are to continue to live independently. Senior Centres provide the elderly with one point of access to many services. They are unique in their ability to give a prompt, highly personalized service utilizing volunteers and existing service agencies.

The Province of Manitoba has adopted a policy to support the development and operation of multi-purpose Senior Centres. The policy provides for operating grants of up to 33% of approved operating costs and requires Senior Centres to adopt the Canadian Institute on Senior Centre (C.I.S.C.) Standards.

Issues:

There are a multitude of sites identified as Senior Centres throughout the province. A minimal number have adopted and implemented C.I.S.C. standards to ensure quality operation.

The well elderly and many more who are at risk and frail are living longer in the community. Where there are concentrations of elderly persons especially in Elderly Persons Housing Units, the neighbourhood Senior Centre whether located within or near the E.P.H., is feeling the impact of an increasingly older and frailer population. However, there are large concentrations of elderly in both urban and rural areas where senior centres do not exist or where an existing senior drop-in centre focuses primarily on recreation.

Delivery of Senior Centre services require staff, operating and capital resources that are often difficult to mobilize.

Colocation of Senior Centres in E.P.H. results in a lack of visibility and reduced accessibility of service to other elderly in the community.

Recommendations:

36) That where the density of seniors in the population is high, (20% of the population 60+ and/or numbers are substantial) a Senior Centre should be established to provide socializing opportunities and services to meet the needs and enhance the quality of the lives of the elderly population in the community.

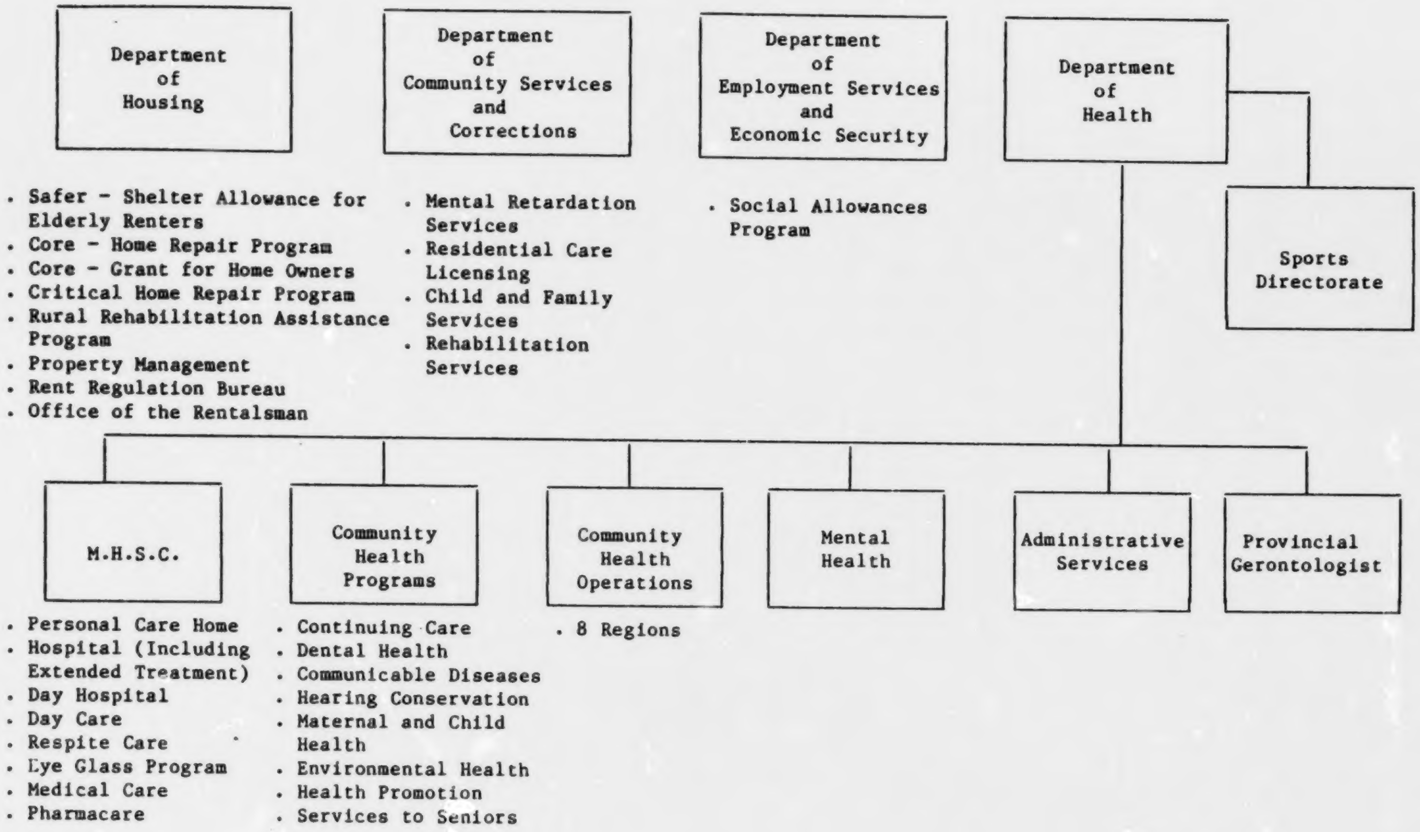
37) That in areas where there are not currently health promotion programs which incorporate surveillance of the frail and at risk elderly, Senior Centres should be requested to perform this function.

38) That implementation of government policy on multipurpose Senior Centres will require the establishment of a pool of capital resources for construction and renovation of Senior Centres. Such capital should only be available to Centres that agree to meet C.I.S.C. standards. The highest degree of accessibility to the total aging community can be achieved if the Centres are free standing in visible locations rather than co-located in Elderly Persons Housing buildings.

APPENDIX A

SERVICES FOR THE ELDERLY

PROGRAM RESPONSIBILITY


Department of Housing
Department of Community Services and Corrections
Department of Employment Services and Economic Security
Department of Health
Sports Directorate
. Safer - Shelter Allowance for Elderly Renters
. Core - Home Repair Program
. Core - Grant for Home Owners
. Critical Home Repair Program
. Rural Rehabilitation Assistance Program
. Property Management
. Rent Regulation Bureau
. Office of the Rentalsman
. Mental Retardation Services
. Residential Care Licensing
. Child and Family Services
. Rehabilitation Services
. Social Allowances Program
M.H.S.C.
Community Health Programs
Community Health Operations
Mental Health
Administrative Services
Provincial Gerontologist
. Personal Care Home
. Hospital (Including Extended Treatment)
. Day Hospital
. Day Care
. Respite Care
. Eye Glass Program
. Medical Care
. Pharmacare
. Continuing Care
. Dental Health
. Communicable Diseases
. Hearing Conservation
. Maternal and Child Health
. Environmental Health
. Health Promotion
. Services to Seniors
. 8 Regions

APPENDIX B

PROPOSED MODEL FOR THE INTEGRATION OF PLANNING AND RESOURCE ALLOCATION RESPONSIBILITY FOR SERVICES THAT EFFECT THE CONTINUUM OF CARE FOR THE ELDERLY

A new Division (to include the Provincial Gerontologist and the Manitoba Council on Aging) within the Department of Health would be responsible for program planning, resource priority setting and allocation for the following list of programs and services:

Personal Care Homes
Extended Treatment Units
Day Hospitals
Day Care
Respite Care
Residential Care
Adult Foster Homes
Elderly Persons Housing Units
Continuing Care
Services to Seniors
Support Services to Seniors

APPENDIX C

INSTITUTIONALIZATION RATE

MANITOBA POPULATION AGE 65+

Population Age 65+	129,468	(June 1, 1984)
NATURE OF INSTITUTUTION	**NUMBER**	
Personal Care Home	7,729	(March 31/84)
Panelled & living in Hospital	682 *	(March 31/84)
Extended Treatment (1)	56	(Nov. 1984)
Active Treatment (1)	9	(Nov. 1984)
Transferred to Deer Lodge Centre (Long Term Intensive Special Treatment)	54	(Nov./83-March 1984)
Selkirk Mental Health Centre (1)	105	(November 1984)
Brandon Mental Health Centre (1)	231	(November 1984)
Manitoba Development Centre (1)	69	(November 1984)
	8,935	

Rate of Institutionalization of Population over age 65 - 6.90%

* Not necessarily over age 65.

(1) Over 65, not panelled but resident in facility for longer than 1 year.

APPENDIX D

EXTENDED TREATMENT PROGRAM COMPONENTS

In Manitoba, extended treatment programs are provided both in hospitals established primarily for that purpose and in specialized units attached to some acute care hospitals. In some hospitals these program components are part of the department of geriatric medicine.

The following definitions have been developed to eliminate confusion arising from different terms being used to describe types of care offered within these programs.

COMMUNITY OUTREACH

Outreach programs are an important part of the continuum of care offered. They may include day hospital, outpatient clinics, pre-admission and post-discharge home visits. Close links are established with family doctors, community nurses, community social workers, community therapists and mental health workers.

SHORT TERM ASSESSMENT AND TREATMENT

A program providing for a short period of comprehensive in-patient assessment which may involve some treatment and involve those members of the health care team that are indicated by the pathology and functional capacity of the patient.

The objectives of this program component are to determine the type and amount of assistance required to achieve and preserve the greatest degree of independence possible and to establish the most appropriate programs and environment for each patient.

REHABILITATION

A program in which the emphasis is on improving functional ability to the level of the individual's capability. Patients should show evidence of benefiting from treatment within three to six months.

The objective of the program is to assist the patient to function satisfactorily at home with or without support; or to prepare the patient for living in a different setting.

NTENSIVE LONG TERM - SPECIAL TREATMENT/CARE (CHRONIC CARE)

This program provides long term care for the patient who has reached his/her maximum level of functional ability and shows little or no potential for improvement but who requires a level of care or special treatment that annot be provided at home with supports or within the personal care home rogram.

he objective of this program is to maintain the patient at the functional evel achieved, in an appropriate long term care setting.

SOCIAL RESPITE CARE

A program intended for persons requiring short periods of pre-arranged admissions as an essential part of the continuing care plan. Admissions usually do not exceed two to three weeks in length and may be planned on an intermittent basis or for a single period.

The primary objective of these admissions is to provide relief for families while at the same time ensuring care in an appropriate setting. Intermittent assessment and adjustment of the patient's care regimen may also occur. These patients have major physical and/or mental problems that cannot be managed appropriately by respite admissions to personal care homes.

There may be occasions when social admissions are necessary due to a crisis in the support network.

APPENDIX E

SERVICES/CARE/TREATMENT CONTINUUM
FOR ELDERLY PERSONS

	INDEPENDENT	SUPPORTED INDEPENDENCE	CARE/TREATMENT IN INSTITUTIONS
		Increasing costs - personal and financial	
NATURE OF SERVICE	Primary Personal Preventive Self Initiated	Personal Care in the Community Support to Individual and Family	Long term Short term/epidsodic
SPECIFIC SERVICES	Housing - C.M.H.C. - M.H.R.C. Senior Centres Senior Clubs Transportation Income Security Public Health Retirement/Education Medical Care	Continuing Care/Home Care Residential Care Outpatient Hospital Care Support Services Day Hospitals	Personal Care Homes Extended Treatment Rehabilitation Acute

REPORT OF THE EMERGENCY HEALTH CARE SUB-COMMITTEE

Members of this committee were:

Dr. T. Lee (Chairman)	Dr. K. McKenzie
Mr. D. Pascoe	Dr. G. Fuchs
Dr. G. Bristow	Ms. B. Zunic
Dr. N. Swirsky	Mr. B. Gudmundson
Dr. G. Borrett	Mrs. N. Schwabe (Recording Secretary)

The overall task of this committee was to identify problems of the Emergency Health Care System in Manitoba and to recommend solutions to the Health Services Review Committee. These recommendations were made with the committee members being cognizant of the interaction between efficacy in the delivery of quality health care, increasing costs, and fiscal restraint.

The format of this report will be to list major problem areas which encompass many factors in the delivery of Emergency Health Care. Following this, specific recommendations will be outlined for each of the major problem areas. If background information is required, minutes of the sub-committee meetings will be made available.

Major Problem Areas

1. Standardization of the delivery of emergency care
2. Shortage of medical beds and proper utilization of hospital beds
3. Shortage of sub-specialty hospital beds
4. Operation of emergency rooms
5. Physician and nurse training to work in emergency rooms
6. Ambulance services and pre-hospital care
7. Promotion of health and preventive medicine

Recommendations

1. Shortage of acute care beds

   The occupation of acute care beds by chronic care patients has been identified by every Winnipeg and some rural hospitals as the major factor limiting the efficient

6.3 WAS personnel should be trained at the EMA II level, and move towards the EMA III training level

6.4 all hospitals that are 60+ beds should have an ambulance service that is hospital based

6.5 all hospitals that are 60+ beds should have ambulance personnel trained at the EMA I level

6.6 all hospitals that are less than 60 beds should have ambulance personnel trained at the First Responder level

6.7 standardization of emergency health care delivery should be implemented province-wide

7. Promotion of health and preventive medicine

7.1 emergency health services should promote patient education and preventive medicine campaigns

7.2 support should be given for seat belt and helmet legislation

7.3 support should be given for education regarding alcohol and driving/speed limits

7.4 promotion of basic rescuer CPR should be given

7.5 workplace health and safety officers throughout Manitoba should be promoted

On behalf of the members of the Emergency Health Care Sub-Committee, we sincerely hope that these recommendations are of benefit to the Steering Committee, Health Services Review.

Submitted by
Norma Schwabe
Recording Secretary

Norma Schwabe

/dc
84/12/05

HEALTH SERVICES REVIEW COMMITTEE
SUB-COMMITTEE ON DISEASES OF THE DIGESTIVE SYSTEM
FINAL - MAY, 1985

Members:	Dr. R. G. Danzinger - Chairman	Dr. K. McIver
	Ms. M. Coe	Dr. W. Myers
	Dr. A. Elliott	Dr. L. L. Roos
	Dr. H. Greenberg	Dr. C. G. Saunders
	Dr. G. R. Grahame	Mr. S. Drain - Secretary
	Dr. R. Kippen	

I. Preamble

Recommendations will mainly be based upon agreement within the Committee on future trends for improved care of patients with gastro-intestinal (G-I) diseases based on:- prophylaxis, diagnosis, and treatment.

Committee members agreed that recommendations should be based first on our assessment of "best" management and second on our assessment of cost effectiveness.

The average age of Manitobans is increasing (ie. we are an aging population); as such, the incidence of cancer (in our sphere colo-rectal cancer) will increase as will other age-related G-I diseases. With increasing patient expectations and increasing occurrences of medico-legal cases, physicians are forced to use the best and safest forms of diagnosis and treatment, hence increasing the demand for the more sophisticated, often more specific technological devices. Since we do not really know the cause of G-I malignancy (with a few minor exceptions) and peptic ulcer disease, at this time it appears that little can be gained from prophylaxis other than promulgating good general health practices.

II. Conclusions and Recommendations

A. Value of M.H.S.C. Data Bank

Statistical information from M.H.S.C. was of limited value in helping the Committee to reach conclusions on which to base recommendations for future management of patients with G-I diseases. Therefore, these will be based only to a small extent on such data.

Value of M.H.S.C. data:

- regionalization of therapy and services
- identification of geographical location of patients with index diseases

When used to identify patients by their home region - there were few wide variations in service delivery.

M.H.S.C. data as it was presented was of limited value but when manipulated appropriately and combined with study of hospital records and "expert" consultation (eg. Cholecystectomy Study presented by Dr. L. L. Roos) can be used to monitor "patterns of practice" and outcomes related to interventions.

Recommendation:

1. M.H.S.C. should consult with skilled epidemiologist/computer experts to develop its data reporting capability to allow "medical" interpretation of the potentially important information being collected and computerized.

B. Availability of Technological Advances

There appears to be disparity in the availability of technological advances throughout the province.

eg.

i) Even major centres are lagging. There are only 2 C.T. Scanners in Manitoba both located in Winnipeg and both with majority of time committed to neurological investigation. There is ample evidence that this is the most specific first test for some G-I/abdominal problems (see C.T. Scanning and Ultrasound later).

ii) Especially rural areas seem to require specific improvements since they lag behind even further than the major centres.
  - particularly diagnostic procedures: Ultrasound (U/S), Computed Tomography (CT), flexible endoscopy.

- also, double contrast upper and lower G-I examinations approach endoscopy in accuracy of diagnosis and may be more cost effective.

There is evidence that introduction of new diagnostic procedures is followed by "phasing out" of older methods and even "streamlining".

eg.: - Intravenous Cholangiography has almost disappeared with the introduction of newer more specific cholangiograms [percutaneous transhepatic (PTC) and endoscopic retrograde cholangiopancreatography (ERCP)] and Ultrasound Scanning.

- direct use of the new better procedure rather than "diffuse" workup then the new procedure. eg. The site, size, and extent of abdominal lymphomas can be determined accurately and more safely by CT Scan than lymphangiography and "staging" laparotomy. The Committee believes that selective use of new more specific diagnostic procedures will lead to a decrease in total number of other procedures being performed. (Table I through IV).

There may be merit (and cost saving) associated with developing regional "operating centres". ie. Rather than every small hospital having a small ill-equipped and poorly staffed laboratory, radiology (diagnostic imaging), and operating room facility, a larger centre serving a "mini region" could attract the necessary specialized personnel and decrease duplication of poorer facilities. This should also result in better patient care.

Recommendation:

2. The Government should investigate the value of developing "mini regions" where concentration of new sophisticated diagnostic and therapeutic modalities should improve health care while preventing costly duplication of inadequate facilities.

C. Management of Some Index Diagnosis

i) Neoplasms of Colon, Rectum, and Anus

- Very serious (life-threatening) and increasing prevalence with aging population.
  - (a) Therefore, prevention and early diagnosis is important.
    - There is information published which suggests there may be prophylaxis with high fiber, low fat diet and prevention of constipation.
  - (b) Early diagnosis:
    - occult blood testing of feces is quick, low cost, easy, and a reasonably sensitive test for screening the whole population.
    - increase endoscopy (both sigmoidoscopy and colonoscopy):
      - for diagnosis and removal of polyps since mounting evidence indicates that polyps precede cancer.
      - for compulsive, timed colonic biopsy in patients with ulcerative colitis since cytologic changes can indicate the presence of asymptomatic cancer.
      - will require improved pathology services to assist in the detection of polyps, cytologic changes, and cancer.
      - will decrease the need for laparotomy for polypectomy (has already reduced the frequency of laparotomy for polypectomy).
    - Double contrast barium enemas:
      - cost effective (cheaper unit cost than colonoscopy).
      - widely available (should be more so)
      - should replace single contrast enemas in most cases.
      - should never occur as the only test of colon, ie. sigmoidoscopy must accompany this test.

    (- CT scan is the best staging test and best method for diagnosis of perineal and pelvic recurrence.)

(c) Therapy:

- Can be simple polypectomy; this may prevent cancer as well as remove "in situ" cancers.
- Definitive cancer surgery usually requires skilled surgeon, anaesthetist, equipped O.R., and full hospital facililities. Should be regionalized.
- Adjunctive therapy includes radiotherapy (regionalized) and chemotherapy (can be done locally).

Recommendations:

3. Health professionals should make population aware of possible benefits of diet and physicians should institute widespread use of stool occult blood testing as a screening test for G-I neoplasms.

4. Double contrast G-I radiologic examinations must be more widely available within the province.

5. Endoscopy (see later), particularly flexible colonoscopy by skilled endoscopists, should be more widely available in the province for diagnosis, prevention, and therapy of localized disease.

ii) Peptic Ulcer Disease

(a) Prevention: Education of the population re diet, smoking, drugs, lifestyle.

(b) Diagnosis:

i) Radiology - less expensive than endoscopy but not as specific.

ii) Endoscopy - more expensive, more specific.

*- Gastric ulcer: essential to obtain biopsies.
- not necessary in majority of patients with benign duodenal ulcers once diagnosis is established.
- has reduced number of upper G-I barium studies (see Tables).

(c) Therapy:

- Most often can be done locally.
- Surgery continues as a therapeutic measure but its frequency has been reduced. Only done by trained surgeons, therefore, should be regionalized.

Recommendations:

6. Double contrast or better quality upper G-I barium studies must be available throughout the province.

7. Upper G-I endoscopy, by skilled endoscopists, should be more widely available in the province.

iii) Groin Hernias

(a) Prevention: None known.

(b) Diagnosis: Clinical, no specific highly technical diagnostic tests are necessary.

(c) Therapy:

- Probably should be a greater move to outpatient (NFA) repairs for the elective uncomplicated cases.
- Need for home care improvements is controversial, ie. the home visits for pediatric NFA surgery may not need to be as intensive or frequent for adult NFA procedures.

Recommendation:

8. Facilities for N.F.A. Surgery must be improved throughout the province. This probably will not require extension of home care programs.

iv) Biliary Tract Disease

- Rapid technological changes here.

(a) Prevention:

- Specific populations have higher risk (eg. natives). These people should be screened for the existence of stones.

- Diet, especially obesity, may play an important role. Population education may have a role to play here.

(b) Diagnosis:

- *- U/S: Is the most specific diagnostic test for cholelithiasis for stones in the gallbladder.
    - therefore, it should be the first test, and a screening test (where available, it has replaced oral cholecystography).
    - need not be whole abdomen; U/S just the right upper abdomen.
    - can be used to biopsy (needle aspiration) for diagnosis and staging of "biliary" cancers.
- In jaundiced patient, CT scan is more likely to be useful in pinpointing site and cause of obstruction than U/S.
- Radiology:
    - continues to play a role in diagnosis and treatment (eg. retained common duct stones; relief of inoperable obstructions), eg. ERCP and percutaneous transhepatic cholangiography.
    - fluoroscopy: stone removal.
- Endoscopy:
    - ERCP:- diagnostic
        - acute therapy (and transhepatic): decompression of obstructed bile ducts.
        - definitive therapy: single stone removal following papillotomy.
- Choledochoscopy: Intra-operative; has decreased the rate of "retained stones".

(c) Therapy:

- Also changing rapidly and radically.
- Endoscopy: drainage of duct obstruction, CBD stone removal.
- X-ray fluoroscopy: drainage, acute and palliative, stone removal.
- Dissolution: oral medications; infusions through transhepatic, "T", and nasobiliary tubes.

- U/S and CT directed biopsy can eliminate some diagnostic and staging surgery.
- Surgery:- elective
  - emergent
  - CBD

  Rates appear to be changing at least partly related to newer diagnostic means and "non-operative" methods of therapy.
- Mini regionalization should improve outcome of therapy when surgery is performed by trained surgeons with proper facilities (both diagnostic and therapeutic).

Recommendations:

9. Ultrasound facilities must be more widely distributed throughout the province (both hospital-based and non-hospital-based). (See later: U/S.)

10. Endoscopy facilities and skilled endoscopists must be available in "regional centres". (See later: Endoscopy.)

11. Intra-operative radiology must be improved in major hospitals to improve operative management of biliary tract disease.

v) Inflammatory Bowel Disease (IBD includes both Ulcerative Colitis and "Crohn's" Disease):

- Prevalence in province not changing in past five years.
- These patients account for above average number of services per patient throughout the province.
- Etiology is unknown therefore prophylaxis is empirical.
- Diagnosis and follow: Involves both radiology and fiberoptic endoscopy. Best radiology is highly technical, eg. double contrast and small bowel enemas.
  - There is concern about "too much x-ray exposure" in these chronically ill patients therefore a reasoned trend is toward follow-up by endoscopy.

    - Colonic cytology, obtained by colonoscopy, appears to be specific and useful in predicting asymptomatic cancer in ulcerative colitis.
- Therapy:
    - Pharmacological can be carried out anywhere in province but requires input from specialists.
    - Surgery usually is very involved requiring subspecialty surgeons and often sophisticated "tertiary care" centres.

Recommendations:

12. Regionalization of more sophisticated radiology and skilled fiberoptic endoscopists are necessary to improve the efficiency of making the diagnosis in these diseases.

13. Routine colonoscopy with biopsy must be promulgated in the follow of patients with ulcerative colitis - another impetus for regionalized expertise in endoscopy.

D. Computerized Tomographic (CT) Scanning

- A rapidly improving diagnostic and treatment modality.
- Superior diagnosis in abdomen:
    - abscesses
    - pancreatic masses
    - liver consistency
    - retroperitoneal masses
    - abdominal trauma
    - assists in biopsy and drainage
- Can be highly specific, therefore it is the best first test in some patients who are jaundiced.
- Availability in province is a problem.
    - could decrease other investigations which are less specific (eg. liver/spleen scans, arteriograms)
    - may decrease U/S for abdominal masses and jaundice
    - may decrease hospital stay (specific anatomical test, quicker)

  - estimated 1/200,000 population are necessary
  - can replace some surgical procedures (eg. biopsies, drainage of cysts, and some abscesses)
  - no facility in the province is dedicated to abdominal CT scanning, therefore, these patients must compete with head (CNS) scans.
- Since it is in short supply, other tests are being "over done" while patients wait on lengthy appointment lists.
- Also, patients from Southern Manitoba are being sent to the U.S. for this procedure. Is that embarrassing and good patient care?

Recommendations:

14. In-hospital availability of C.T. Scanning must be improved in the province (to a minimum of 1/200,000 population) to facilitate its use in patients with non-CNS problems.

15. A fee schedule must be developed to allow payment for interventional procedures carried out with use of C.T. Scanning (biopsy, drainage, etc.).

E. Ultrasound (U/S)

- Safe (no radiation), non-invasive, quick.
- First test for cholelithiasis.
- Not available throughout province (long waiting lists).
- Can be cost effective
  - if limit area scanned
  - can replace other tests
  - less expensive than CT to initiate and maintain
- With present long waiting lists, patients are sometimes admitted just to obtain this diagnostic test. This is not cost effective.
- Need not be confined to hospitals. Appropriate fee schedule would allow private facilities to develop.

Recommendations:

16. Both in-hospital and private office availability of Ultrasound must be improved in the province.

17. A fee schedule must be developed to allow payment for interventional procedures carried out with the use of Ultrasound (eg. biopsy, drainage, etc.).

F. Nuclear Magnetic Resonance (NMR or MR Imaging) Scanning

- Must consider this in the very near future.
  (a) Anatomical imaging.
  (b) "Functional imaging": tissue specific, tissue function, eg. nutritional status.
- No radiation exposure.

Recommendation:

18. The province must be prepared to introduce this diagnostic procedure if it meets its early expectations as a superb diagnostic tool in certain circumstances.

G. Flexible Fiberoptic Endoscopy

- There is a general trend toward increasing use of endoscopy of the G-I tract.
- This is both diagnostic and therapeutic.
- Per test, it may be less cost efficient than barium radiology, but it is frequently more specific. Has reduced upper G-I barium studies (see Tables) and may have decreased surgery for presumed gastric cancer.
- Certainly there is regional disparity in Manitoba both in terms of skilled physicians and availability of appropriate instruments and facilities.
- Its use will continue to increase as instruments improve and as more physicians learn their use, eg. flexible sigmoidoscopy.

- Diagnostic endoscopy (except ERCP) could be done safely in an office situation with judicial use of sedatives reducing cost of hospital facilities. An appropriate fee schedule must be developed to allow this. Probably therapeutic endoscopy and that requiring radiology are best kept as hospital procedures.
- Special virtues:
  - non-operative polypectomy may eventually decrease incidence of colo-rectal Ca.
  - variceal sclerotherapy is as effective as other therapy and much less expensive in management of bleeding from esophageal varices.
  - biopsy of ulcers and polyps: both upper and lower G-I tract.
  - specific operative procedures, eg. foreign body removal, control of bleeding.

Recommendations:

19. Facilities must be developed and skilled physiciars/surgeons must be located in strategic regionalized centres in the province.

20. An appropriate fee schedule must be developed to allow diagnostic endoscopy to develop in private offices leaving hospital facilities less congested and more specifically prepared for therapeutic endoscopy (which may require radiologic assistance and/or operating room backup).

H. Sigmoidoscopy

Rigid sigmoidoscopy is still not done as often as necessary. It may be slowly replaced by flexible sigmoidoscopy. It is potentially easy and very useful both diagnostically and therapeutically. Must make this procedure easy to do. In some areas in the province it is rarely done, eg. Norman.

Recommendations:

21. An appropriate fee schedule and easy access must be developed to encourage the use of this very important diagnostic and therapeutic measure.

22. Provision must be made for the replacement of rigid sigmoidoscopy by flexible fiberoptic sigmoidoscopy in some private offices and "regional centres".

TABLE I
RADIOLOGIC EXAMINATIONS DONE/12 MONTHS

	1969	1970	1975	1979/80	1983	1983/84	1984
Stomach & Duodenum:							
Winnipeg Clinic	2630				1432		
Manitoba Clinic			1355				1062
Health Sciences Centre		1795	1466	1079		944	
Barium Enemas:							
Winnipeg Clinic	1560				815		
Manitoba Clinic			808				649
Health Sciences Centre		1128	1085	698		702	
Oral Cholecystogram:							
Winnipeg Clinic							
Manitoba Clinic			590				267
Health Sciences Centre		663	630	437		204	
Intravenous Cholangiograms:							
Winnipeg Clinic							
Manitoba Clinic							
Health Sciences Centre		123	179	110		38	

1. With the introduction of fiberoptic endoscopy (perhaps also related to U/S), barium examinations of both the upper and lower G-I tract have decreased in number annually.
2. Intravenous cholangiograms have almost been completely replaced by other more specific cholangiograms.
3. Oral cholecystography is disappearing as ultrasound is more widespread.

TABLE II

GASTROINTESTINAL EXAMINATIONS/SCANS

(More Detailed Look at Health Sciences Centre)

		1979-80			1983-84		
	Procedure	In-Pt.	Out-Pt.	Total	In-Pt.	Out-Pt.	Total
7073	Esophagus	93	119	212	95	120	215
7074	Stomach & Duodenum	472	601	1,073	415	529	944
7075	S.&D. & Small Bowel	128	163	291	93	119	212
7076	Small Bowel Series	14	17	31	15	19	34
7077	Barium Enema	307	391	698	309	393	702
7078	Contrast Enema	44	55	99	42	53	95
7079	Cholecystogram	192	245	437	90	114	204
7080	I.V. Cholangiogram	48	62	110	17	21	38
	TOTAL	1,298	1,653	2,951	1,076	1,368	2,444

	1980-81			1983-84		
	In-Pt.	Out-Pt.	Total	In-Pt.	Out-Pt.	Total
C.T. Body Scans	228	809	1,037	453	1,631	2,084
Lymphangiograms	46	82	128	23	70	93

1. Similar comments as Table I.
2. C.T. body scans are replacing lymphangiograms.

TABLE III
GASTROINTESTINAL EXAMINATIONS/SCANS

	1979-80		1980-81		1981-82		1982-83		1983-84	
	In-Pt.	Out-Pt.	In-Pt.	Out-Pt.	In-Pt.	Out-Pt.	In-Pt.	Out-Pt.	In-Pt.	Out-Pt.
Radiology	1,540	1,793	1,471	1,729	1,465	1,678	1,403	1,625	1,309	1,487
Body Scans	Not available		228	809	323	1,145	394	1,444	453	1,631

1. Decrease in G-I Radiology with increase in body scans.

TABLE IV
GASTROINTESTINAL TRACT: RADIOLOGIC EXAMINATIONS
PRIVATE DIAGNOSTIC FACILITIES (WINNIPEG & BRANDON)

Tariff No.		1981	1982	1983
7073	Esophagus	3,134	2,534	2,472
7074	Stomach & Duodenum	29,399	29,802	28,913
7075	S.&D. & Small Bowel	2,590	3,058	3,826
7076	Small Bowel Series	438	366	300
7077	Barium Enema	15,439	15,068	14,732
7078	Air Contrast Enema	1,230	1,374	2,202
7095	Barium Enema & Air Contrast	306	278	330
7079	Cholecystogram	18,820	18,890	17,416
7080	I.V. Cholangiogram	272	66	24

1. Definite decrease in esophageal exams.
2. ?Decrease in upper G-I exams.
3. Definite decrease in single contrast enemas as double contrast examinations increase.
4. Definite decrease in oral cholecystograms.
5. Intravenous cholangiograms are being phased out completely.

REPORT OF THE
SUBCOMMITTEE ON INDIAN HEALTH CARE
TO THE
HEALTH SERVICES REVIEW COMMITTEE
MANITOBA

May 1985

Health Services Review Committee
Subcommittee on Indian Health Care

31 May 1985

David Pascoe
Chairman
Health Services Review Committee

Sir:

I am pleased to present the Report of the Subcommittee on Indian Health Care, on behalf of the members of that Subcommittee, for the consideration of the Health Services Review Committee and the Minister of Health of the Government of Manitoba.

The recommendations of the Subcommittee are broad in scope and general in nature. The time and resources available to the Subcommittee necessitated the generality. Our recommendations should be seen as direction setting first steps which will involve changes (and likely increases) in expenditure patterns now, with significant cost (and human) savings to be realized in the future.

Specific plans will be best developed by the tripartite process, which along with local or self-control, forms the central theme of our advice. To formulate specific plans at a Subcommittee level would not be consistent with our general recommendation of full consultation and cooperation between and involvement of, all concerned parties.

With the per capita costs of health services to Indians running at, by one estimate, 2 times the costs for other Manitobans; with indications that progress in narrowing the health gap between Indians and non-Indians has seriously slowed - there will have to be full and unfettered discussion involving all who are concerned, and there will have to be movement on control as well as consultation issues.

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It will be up to the Government of Manitoba to carry forward the momentum of this difficult assignment. I commend the recommendations to the Health Services Review Committee as a framework within which to begin.

Respectfully submitted,

Brian D. Postl, M.D., F.R.C.P.(C)
Chairman
Subcommittee on Indian Health Care

Acknowledgements

Many individuals and groups contibuted to the work of the Subcommittee. It was not always easy to acknowledge the help at the time it was given, but it was very much appreciated. This is especially true of the numerous guests and observers who joined in various sessions to support our efforts with their input.

The Subcommittee joins in expressing its sincere thanks to the following people who contributed to the deliberations of the Committee and assisted in its work.

Mr. Brian Gudmundson of the Provincial Department of Health, Research and Planning Directorate, provided valuable data with assistance from others at the Manitoba Health Services Commission, the Department of Health and the Medical Services Branch of the Federal Department of National Health and Welfare.

The Subcommittee meetings were ably recorded by Mrs. Phyllis MacDonald of M.H.S.C., who in turn had valuable assistance from Mrs. Lou Frederick and others at the Northern Medical Unit, Faculty of Medicine in facilitating arrangements for meetings.

The assistance of Dr. Beverly Elliott, Mrs. Charlotte Johnson and Mr. Robert Whitmore in preparing the Report of the Subcommittee deserves special thanks and acknowledgement.

The completion of the Report after numerous drafts and many changes is very much to the credit of Mrs. Jenni Morris, who utilized her many skills in word processing to put it to paper.

While gratefully acknowledging the help received in so many ways, the Subcommittee itself bears responsibility for the judgements expressed in this report.

SUBCOMMITTEE ON INDIAN HEALTH CARE

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REPORT OF THE SUBCOMMITTEE ON INDIAN HEALTH CARE

EXECUTIVE SUMMARY

The Subcommittee on Indian Health Care of the Health Services Review Committee has undertaken a lengthy and extensive, but not exhaustive review of the health conditions of Manitoba's Indians and the Inuit of the Keewatin area of the Northwest Territories to the north of Manitoba.

The Subcommittee also considered the health care circumstances of Metis and Non-Status Indian Manitobans (and to some extent the conditions affecting northern and isolated communities which are not predominantly native). While there was no effort made to in any way exclude other native groups from the Subcommittee's considerations and Report, the sheer magnitude of the issues and real dearth of adequate data prevented the Subcommittee from dealing substantively with Metis and Non-Status Indians, and to a lesser extent, with urban Indian populations. Many of the principles and general recommendations of the Subcommittee would none-the-less apply to communities and groups representing native peoples who are not registered as Indians and/or not residing on reserves.

Subcommittee membership included representatives of the Federal, Provincial and Territorial Governments, Indian organizations, and the Faculty of Medicine of the University of Manitoba. It worked harmoniously and with reasonable consensus. At the same time, this is clearly not an 'expert' report. That is not to say that the Subcommittee was incapable of expert opinion. In fact, all of the Subcommittee members have considerable experience and expertise in this area and many, as individuals, would be considered expert.

The terms of reference were too large, the issues too complex, the history and jurisdictions too muddled and entangled, for a volunteer Subcommittee, without adequate time and with little in the way of resources, to reach complete closure. This does not mean the Subcommittee's discussions were less valid or the conclusions and recommendations less important.

That the health of Manitoba's Indians is far below acceptable levels on any health status index is beyond dispute. The same can be said of Keewatin Inuit who receive most of their hospital care within Manitoba.

In Manitoba as a whole, the burden of chronic and lifestyle diseases dominates any epidemiologic description.

Indians and Inuit find themselves with the additional burden of infectious diseases, not too far removed from that experienced in developing countries. Otitis media and meningitis affect proportions of the childhood population that would be considered scandalous in other populations. Indian and Inuit children are now virtually the only source of new rheumatic fever seen in our hospitals. Chronic conditions are themselves increasing. Diabetes is now considered to be epidemic in the adult Indian population. Patterns of malignancy are changing to more closely approximate that of western cultures, and chronic lung disease is endemic. Overcrowded housing, poor water and sanitation, and high unemployment contribute to the ill health of Indian people. The impact of these social and environmental indices on health is evident in suicide rates and psychiatric illness that far exceed national averages.

All of these factors contribute to a rate of service utilization that is highly disproportionate to the general population. Large amounts of monies are being expended and the impact of that expense is less than we might hope for. Superimposed on these problems are bureaucratic structures and jurisdictional wrangles that lead many Indians and Inuit to the frustrating perception that the system is insensitive to their needs and uncaring of their aspirations.

In discussing the genesis of these problems and perceptions, a number of points became dominantly clear to the Subcommittee:

> Despite the large accumulation of aggregate data specific to the health of Indian and Inuit people, there as yet exists only an incomplete database on which to plan programs. This database must be improved by the joint efforts of federal and provincial (and territorial) governments and must be fully available to Indians and Inuit. Research is an increasingly important aspect in program planning and evaluation. Increased or reallocated funding should be specifically identified for research related to Indian and Inuit health. These funds should be distributed only with the full involvement of Indians and Inuit.
>
> Historically, a special relationship has existed between Indians and the Federal Government. That relationship continues to exist. It should not however, as has been the case, preclude a formal relationship between Indians and the Provincial Government. As the insurer and provider of health

services to Manitobans, the Government of Manitoba provides a substantial percentage of the health care dollars expended on behalf of Indians. It is inevitable and desirable that the Provincial Government be seen as a partner in the provision of health services to Indians.

As part of the responsibility of both governments, it must be recognized that much of the suboptimal health seen in Indian and Inuit communities is social and environmental in origin. Despite the fact that social and environmental jurisdictions are separate from those of health, renewed efforts must be made to bridge the gaps between the branches of government and between governments. Efforts to significantly and efficaciously improve health without addressing this fact will fail.

It was evident throughout our deliberations that there was a common theme that appeared time and time again; that Indians must be involved in and have control of health care delivery in Indian communities. That theme is the fulcrum by which changes in health will most likely occur.

If the profound health issues affecting Indians are to be addressed, Indians must themselves be full partners in the planning, implementation and evaluation of health programs. Resources must be made available to allow them to develop the expertise required to negotiate and act as full partners with all levels of government. In effect, a tripartite arrangement of equals must be established.

The same jurisdictions were represented in our deliberations. If the spirit of our activities is continued at senior levels, much will be accomplished towards the overall goal of improved health for Indians and Inuit.

SUBCOMMITTEE ON INDIAN HEALTH CARE

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REPORT OF THE SUBCOMMITTEE ON INDIAN HEALTH CARE

Terms of Reference

In 1984 the Minister of Health of the Government of Manitoba established a Health Services Review Committee to examine alternatives in health services delivery which would minimize cost increases while still assuring provision of quality of health care. As well as considering immediate issues such as cost constraint, the Committee was asked to look at future issues such as structures for health service delivery.

Subcommittees to the Health Services Review Committee were formed to investigate particular topics which required additional analysis and review, and to provide recommendations on these specific topics to the main Committee. One of these Subcommittees was the Subcommittee on Indian Health Care.

The terms of reference for the Committee and this particular Subcommittee were generally:

Health Services Review Committee

1. To identify major cost centres and explore the possibility of consolidation.
2. To look for alternatives to inpatient service delivery systems; (for example, delivery on a not-for-admission or ambulatory care basis).
3. To review current bed allocations and the appropriatness of numbers and utilization of this resource.
4. To review criteria for hospital admissions in both Winnipeg and rural hospitals.

Subcommittee on Indian Health Care

1. To review the existing health status of Indians and Inuit in Manitoba and the Keewatin District, Northwest Territories, and to identify how that health status is reflected in hospitalization patterns.

2. To review structures in place relevant to health services received by Indians and Inuit in Manitoba and the Keewatin District, Northwest Territories.

3. To review manpower needs and educational status and needs relevant to Indian and Inuit health.

4. To review the social, cultural, political and structural barriers to the delivery of effective health services to Indians and Inuit.

5. To examine potential efficiencies within the existing health system while maintaining efficacious health care.

6. To make recommendations relevant to the efficient improvement of health status of Indians and Inuit, estimating the impact upon the quality of health care available in the future while accepting prudent fiscal restraint.

Background

Population

The Indians of Manitoba number about 50,000, and include 3 important language groups and 5 dialect groups. There are Status Indian Communities and reserves in all parts of Manitoba and most individuals belong to one of 60 bands.

In addition to the Status Indian population, which has a special relationship with the Federal Government, there are other native peoples (Metis and Non-Status Indians) who rely primarily upon the Province of Manitoba for their health services.

To the north of Manitoba, in the Keewatin District of the Northwest Territories, are some 5,500 Inuit who have access to most of the Federal Government services provided to Status Indians. Their geographic proximity to Manitoba has led to a special set of health care arrangements linking the territorial jurisdiction and the largely Inuit population to health care services in the Province of Manitoba, specifically those provided by the Churchill Health Centre and the University of Manitoba, Northern Medical Unit.

The Subcommittee on Indian Health Care was primarily concerned with health services to Status Indians and with those health services to the Inuit of the Keewatin that involved some relationship with Manitoba. (See Appendix 1, a-1) Services to other northern and isolated communities, and to urban natives other than Status Indians received some attention, however there were difficulties encountered in terms of insufficient data and a shortage of time available to the Subcommittee. Consequently, the Subcommittee focused its deliberations on the health situation of Status Indians. It is recognized that Inuit, Non-Status Indians and Metis generally face similar circumstances. (See also Appendices 4 and 5)

Background

Health Status

The state of ill-health among Canada's Indians and Inuit has been well documented and received much attention by governments and other interested groups. More recently Indian organizations have placed a high priority on health. There continues to be a gross disparity in health status between Indians and non-Indians. There are, however, changing trends and underlying factors which must be examined in an historical context to more fully understand the situation.

Changes in lifestyle, crowded living conditions, changing diets and a lack of resistance to diseases introduced by the Europeans led to widespread epidemics in the 1800's. Smallpox, whooping cough, measles, chicken pox, diptheria and influenza swept through the Manitoba Indian population in the late 1800's.

Throughout the twentieth century there has continued to be a wide gap between Indian and non-Indian health status indicators. Infant mortality rates and infectious disease rates have consistently been higher amongst Indians.

An important shift in disease patterns is now occurring in Indian and Inuit communities. Morbidity and mortality due to infectious diseases and to maternal and infant illness are decreasing, while those due to chronic disease conditions, the diseases of 'lifestyle', are increasing. Although this so-called 'second epidemic' has occurred in all 'industrialized' populations, the change has happened in a much shorter period of time and with greater severity for Indians, and is superimposed on the as yet incompletely resolved 'first epidemic' of infectious diseases.

Evidence of the falling incidence of infectious diseases is found in various health status indicators. Infant deaths of Manitoba Status Indians, which were largely due to respiratory and gastrointestinal infections in the past, have fallen from almost 100/1000 livebirths in the early 1960's to 17/1000 livebirths in 1983 as compared to rates of 25 and 10.5 per thousand in other Manitobans. (1) (Figure 1) The infant mortality rate for the Inuit in the N.W.T. has fallen from 90/1000 livebirths in 1968 to 39.5/1000 livebirths in 1983. (2)

Infections in the childhood and adult population are still major problems, although here too there is a general trend towards improvement. Manitoba Indians are hospitalized at a rate 4 to 7 times that of the general population for various disease conditions. (Table 1) The major infections are gastrointestinal, tuberculosis, meningitis, otitis media and hepatitis. For example, meningitis is recognized as being much more frequent in Indian and Inuit children, with a recent study showing that 7% of Inuit children in the Northwest Territories acquire meningitis in the first 8 years of life, approximately 200 times that in the general population.(3) Otitis media is still a major cause of morbidity, resulting in impaired hearing in both Indian and Inuit children. Nearly 50% of Indian and Inuit children suffer episode(s) of otitis media in the first few years of life. The impact of this burden is unknown.

Despite extensive control programs, there is still a much higher incidence of tuberculosis in Indians. From 1961 to 1982, in the general population of Manitoba, the incidence of new and re-activated tuberculosis had fallen from 32 to 14 per 100,000, whereas that in the Indian population had fallen from approximately 350 to 110 per 100,000. (4) (Figure 2) In 1983, there was an epidemic resulting in a rate of 190 per 100,000 in the Status Indian population. (Table 2) Manitoba Health Services Commission data reveal that in 1982-83 the rate of hospitalization for tuberculosis was 24 times higher in the Indian than in the general population. (Table 3)

Reductions in infectious diseases, and in infant and maternal death rates, have been the result of improvements within and beyond the health services provided over the past century. Improvements in living conditions, housing, sanitation, maternal and child care, tuberculosis control programs and other public health measures have all contributed to this trend. However, as evidenced by the continued disparity between Indian and non-Indian health status indices, there is still need for continued strong efforts in all of these areas.

Chronic diseases, including heart disease, respiratory disease, diabetes, cancer and mental illness are of increasing importance and proportion in the disease burden on Indians. This increase is due to many factors yet poorly understood. However, it is partially explained by increasing numbers living to older ages, by changes in lifestyle and diet, and by social and cultural upheaval.

In 1979, national statistics showed that 23% of all deaths in Canadian Indians were caused by diseases of the circulatory system (heart disease and stroke), 8% by cancer, and 7% by diseases of the respiratory system, (Statistics

Canada - Figure 3). The proportions of these will continue to increase to reach that in the non-Indian population, as increasing numbers of Indians reach older ages. The present native population pyramid, along with increased life expectancy, indicates that there will increasingly be larger numbers in the older age groups, with concomittant diseases (Figure 4).

Accidents and violence continue to be the leading causes of death of Indians in Manitoba and in 1983 accounted for 28.6% of all deaths, (1) as compared to 6.7% in other Manitobans. (5) The group most likely to die from accidents or violence are males aged 15-44 at the peak of their productivity. The main subgroups are motor vehicle accidents, drownings, homicide, suicide and deaths resulting from fires. Suicides are a major cause of mortality in males in the 15-50 year age group. These occur episodically and therefore numbers fluctuate from year to year. The average annual incidence of suicide among Status Indians in Manitoba from 1981-1983 was 36/100,000 compared to 13/100,000 in other Manitobans. (5) Most of the accidents and violent deaths are alcohol or drug related.

Manitoba Health Services Commission data reveal that for almost every disease category, the Status Indian population uses hospitals both more frequently and for longer lengths of stay than other Manitobans. Although these rates may be due to excessive morbidity in Indians, this data must be interpreted cautiously as utilization may be affected by many other factors, including accessibility to services and the practices of health care professionals. (Tables 4 - 10)

It is apparent from this rather incomplete overview of the health status of Indians in Manitoba, that they are still faced with a heavy and changing disease burden. In addition to the continued need for high quality medical treatment and preventive services, there must be renewed emphasis on environmental, socioeconomic and lifestyle health-related issues and consequent multidisciplinary responses to the health concerns facing Indians and Inuit.

Background

Social, Political and Historical Context of Indian Health Care

Prior to the arrival of Europeans in what is now Canada and throughout the first centuries of contact, Indian and Inuit peoples relied on traditional lifestyles and remedies as protection from and for the resolution of health threatening circumstances. These "systems" of health care revolved around familial and community inter-dependance, natural products and the special gifts of recognized care-givers within the community.

Health care and health care systems as they are known today did not impact on indigenous peoples until the latter part of the nineteenth century, the result both of contact through the establishment of the reserve system and the increasing threat of diseases new to Indians and Inuit.

The provision of health services to Indians and Inuit has traditionally been a responsibility of the Federal Government. The British North America Act (BNA) of 1867, while giving provinces jurisdiction for health care in general, also provided that Indians and Indian lands would remain under the jurisdiction of the Federal Government. Neither the BNA Act nor the Indian Act of 1874 provided specific direction or parameters relative to the provision of health care. Though Treaty No. 6 (1876) specifically refers to the provision of a medicine chest "kept at the house of each Indian Agent for the use and benefit of the Indians at the direction of such Agent", court decisions have refuted its modern day implication that all health services are to be provided to Indians free of cost.

The Federal Government has however assumed increasing responsibility for the provision of services.

The development of health services and health service systems by the Federal Government, specifically directed towards Indians, has been well documented by Dr. K. Young, University of Manitoba. His article on Indian Health Services in Canada: A Sociohistorical Perspective, details the early days of itinerant care that was preoccupied with the containment of dread diseases, and describes the organizational, social and policy changes that have resulted in the present extension of services. (6)

Since 1945 Indian health services have been the responsibility of the Department of National Health and

Welfare. In 1962, Medical Services Branch was created to draw together several previously disparate functions of the Department; this Branch continues to assume responsibility for services to Indians and the residents of the Yukon and Northwest Territories. Indian and Northern Health Services represent the Branch's largest function, consuming over 90% of its human and financial resources.

The Branch is divided into ten regions, of which Manitoba is one. The Medical Services Branch, Manitoba Region is divided into two operational zones, North (headquartered in Thompson) and South (headquartered in Winnipeg). Both zones are occupied entirely with the Indian Health Program whereas Regional Headquarters, located in Winnipeg, assumes additional responsibilities for the Branch's other mandated programs - Public Service Health, Immigration and Quarantine, Environmental Contaminants and Regulatory programs. The Manitoba Region is staffed with a total of 372 personnel who have specific field responsibilities in treatment or community health programming.

The legislative, jurisdictional and practical boundaries between the Federal and Provincial Governments on issues relative to Indian health have been and continue to be poorly defined. Since the introduction of universal medical care insurance in 1969, Indians have been guaranteed access to medical care under provisions identical to those applicable to all residents of the same province. In Manitoba, the Manitoba Health Services Commission assumes financial responsibility for the medical care received by Indians both in hospital and where direct medical services are readily accessible. Physician services in isolated communities are often arranged for and subsidized by the Federal Government in order that ready access is assured.

In respect of community (ie. public) health services, the Federal Government assumes the lead role, providing community health services to 50 of the 60 Indian bands throughout the province. Those bands receiving services from the Provincial Government do so by virtue of the Canada-Manitoba Agreement of 1964 which determined the federal/provincial willingness to provide direct services to one another's clientele, where geography and the existence of established service systems made this economically desirable. Even so, the majority of provincially serviced reserves benefit directly from the continued involvement of the Federal Government through the Community Health Representative, Native Alcohol and Drug Abuse Program and capital programs, as well as through the extension of uninsured benefits.

Indian bands/organizations and the federal and provincial governments have similar goals in the provision of health care. All define their goals in health in a broad, comprehensive fashion, encompassing the physical, mental, social and spiritual well-being of the individual and the community. Self-reliance and control of one's destiny are seen as integral components of such a state.

There is also general agreement as to the major determinants of ill-health within the native population. It is evident from the previous figures on morbidity and mortality that much of the ill-health of Indians stems not only from biological but from environmental and socio-cultural conditions. Accepting the magnitude of the effect of the environment on health means recognizing that many of the health issues lie outside the mandate of a health department. Other factors such as employment, education, and the degree of the community's self-reliance also have a profound impact on health.

In the Indian Health Policy of 1979, (See Appendix 6), deference was shown to the right and responsibility of Indians to determine their destiny in relation to individual and community health. The Policy's overriding goal is stated as:

> "To achieve an increasing level of health in Indian communities generated and maintained by the Indian communities themselves."

The policy is founded on three "pillars" or principles. The first, community development, suggests that the major barriers to improved health amongst Indian people are poverty and apathy and that it is these factors to which the energy of both health services providers and the Indian people must be directed.

The second pillar reaffirms the special relationship between the Federal Government and the Indian peoples of Canada and commits an "open book" policy to promote the greater involvement of Indians in the government's decision-making relative to health care.

The third pillar describes the Canadian health care service system that is made up of numerous private and public jurisdictions. It encourages the full use of the system by Indians and promotes the increasing part that Indians can play as purveyors of health care.

Medical Services Branch nationally has implemented several programs in support of this policy. The Native

Alcohol and Drug Abuse Program, a community-based program, has now funded programs on nearly all of Manitoba's reserves. In addition, the Indian and Inuit Health Careers Program has been established to promote (and fund) the development of programs that will increase Indian access to recognized programs for the training of health professionals and to encourage individual students through the awarding of bursaries. The Community-Based Health Demonstration Program has funded 30 health care projects nationally during the period April 1983 to March 1986, (two in Manitoba), to demonstrate the efficacy of transfer of control.

Though Manitoba Region participates in all such programs, it is unique for its Community-Based Health Services Directorate which is staffed by Indian people to undertake activities related to Transfer of Control, Community Development and Training.

At the same time, increasing political attention has been focussed on Indian self-government. Discussions in this regard are taking on a more practical note, with First Ministers discussions, as an outcome of the Constitutional Act, deliberating on the terms and conditions that will proceed constitutional amendments. Throughout the process of these political discussions, the Federal Government has reviewed in the Penner Report on Indian Self-Government, the service arrangements between the Federal and Indian governments and has recommended significant changes on the constitutional, legislative and administrative fronts.

An important aspect of the Social, Political and Historical Context of Indian Health Care is the organization of Indian governments today. In Manitoba approximately 38,000 status Indians from 60 bands live on reserve, (upward of another 20,000 live off reserve).

The elected Chief and Council of each band comprise the local government. Though circumstances of each band differ widely in population, access to health care services, and the degree to which programs are locally administered, it should be noted that many bands operate their own educational, economic development, social development and health programs (five bands in Manitoba provide community health services under local control).

Tribal Councils also play a major role in the delivery of services to band members. Seven Tribal Councils exist in Manitoba and these count in their constituency all but a handful of unallied bands. Tribal Councils have, to a significant degree, replaced the Department of Indian Affairs and Northern Development district offices and assume control of education, child and family service programs, local government and financial advisory roles. Their capacity to assume increased responsibility for the provision of federally mandated programs is established.

Three larger and overtly political associations of bands exist in Manitoba. The Manitoba Keewatinowi Okimakinak, First Nations Confederacy, and Brotherhood of Indian Nations function as political voices of larger collectives of the Indian people. Essentially representing the north, south and Interlake respectively (with some small variation), these organizations consult with all levels of government to map the way to greater Indian control of Indian life.

Discussion and Recommendations

The Subcommittee on Indian Health Care met in a series of 10 weekly meetings in the months of October-December 1984. Each meeting involved a review of major health issues affecting Indians and Inuit. The list of topics included current health status; morbidity, mortality and utilization indicators; health service structures and health jurisdiction interaction; health care manpower and education programs; the health status of urban Indians and rural to urban migration; health care research and evaluation issues; referrals and evacuations to health care services on a regional basis and province-wide; regionalization of services; socio-political contexts of health services; health care services to the residents of the Keewatin District, Northwest Territories both in Manitoba and as delivered from Manitoba to that region; and the control of health programs. (See Appendix 2)

The complex problems, service structures and organizational issues that are inherent to health services delivered to Indian and Inuit communities and individuals led to discussion which was often wide ranging and difficult to focus.

To better facilitate a clearer presentation and analysis of the Subcommittee's recommendations in the context of their interpretation of the issues as discussed, a shorter listing of more general headings is used here to organize the report.

The Organization and Control of Health Services

The review of the historical context has illustrated the complex relationship existing between Indians and Inuit and the governments of Canada and the provinces or territories. The relationships have been based on various definitions of special status, rights and jurisdictions. These rights issues have created a body of law that is unique and separate in both legislation and interpretation, and continues to expand rapidly as still outstanding claims are dealt with. The recently proclaimed Charter of Rights and Freedoms has not been in place long enough to fully demonstrate its impact, although there seems little doubt that it too will manifest itself in the field of aboriginal rights and status.

The special status that has emerged as a result of this unique history is as apparent in the organization and delivery of health care services as it is in other activities. Responsibility for the provision of health care services to Status Indians on reserves has been assumed by the Federal Government, although arrangements vary in different provinces and in the territories.

Certainly there has evolved a system of health care services that is in many ways separate from the systems serving other Canadians. The Federal Government has provided direct health services to Indians to meet particular needs and where conventional services were unavailable or not readily accessible.

The Subcommittee throughout its meetings noted the inefficiencies inherent in health care services involving two "parallel" delivery systems operated by the Federal and Provincial governments. While accurate data on the costs of operating two separate services were not available, it was agreed by the Subcommittee membership that to continue with the present methods of providing services would continue to result in increasing inefficiency and increasingly higher costs than a single system, without resolving the current gaps in the services provided.

Both levels of government, as well as Indian communities, have a stake in reordering the current arrangements. For the Province, the costs of the consistently and substantially higher than average hospital utilization rates of the Indian population, while offset by federal cost sharing, are enormous. The Federal Government faces a large and growing financial burden through its involvement in the provision of both insured and non-insured services and the maintenance of a separate health service entity. Indians, in turn, see improvements in their health status occurring very slowly in an environment with many health threats, and a largely treatment-oriented health care system where they have little direct input, control and responsibility. In turn, dollars flowing from either government into expensive treatment services are dollars that can not then be spent on preventive health care measures and improvements to community environments.

The issue of control, and especially local control of health care policies and programs by Indian communities (and non-Indian communities) emerged at almost every meeting of the Subcommittee. Local control, in turn, was inextricably bound with social, political and jurisdictional issues and the concept of Indian self-government.

Self-control of health programs and services can be defined quite differently by different groups and individuals and is consequently quite open to misinterpretation.

Self-control was generally defined by the Subcommittee to mean the acceptance by Indian communities, and/or groupings of communities, of full responsibility for a significant proportion of those health services, programs and activities which could either be effectively delivered within the defined catchment area or effectively coordinated from the defined area by the local health authority. It was recognized that the devolution of responsibility would require a concommitant devolution of authority, control over physical plant facilities and equipment, provision of adequate operational and capital resources, and accountability.

The Subcommittee recommends:

1. **That the Government of Manitoba and the Government of Canada, in consultation with Indian communities and organizations, jointly set up a mechanism for the transfer of health services delivery to local control. Resources required to enable the transfer should be identified, along with implementation steps, new structures and a realistic timetable. Resources should, where possible, come from existing allocations rather than being newly sourced, and be provided jointly by the Federal and Provincial Governments.**

   The transfer to local control process should not simply address narrowly-defined health services, but should be part of a broadly-based plan to

redress problems with community systems and infrastructure such as housing, environmental services, education and employment. To this end communities will require resources for consultation, negotiation, agency and service organization restructuring, administration and operational delivery of services.

Northern communities that receive health services from the Government of Manitoba should also be involved in a transfer to local control process that parallels the transfer recommended here for Indian communities.

2. **That in the interim, pending the necessary political decisions, movement towards local control should continue and be encouraged at the senior administrative levels of both government (Federal and Provincial) and Indian organizations.**

Further, while appreciating that it is a "creature" of a provincial Health Services Review Committee which is reporting to the Minister of Health of the Province of Manitoba, the Subcommittee recognized the inter-governmental and inter-jurisdictional nature of its assignment, and therefore recommends:

3. **That the report of the Subcommittee on Indian Health Care be communicated by the Minister of Health of Manitoba to the Minister of Health and Welfare, Canada; to all of the Indian Bands in Manitoba; and to the offices of organizations which will have an interest in the recommendations of the Subcommittee,** in order to facilitate cooperative interdepartmental, intergovernmental and community-based joint efforts aimed at quickly and practically resolving basic issues involving community infrastructure and local economy, services and environmental facilities (e.g. sewer and water).

4. **That there be regular and adequately resourced meetings between the Governments of Manitoba and Canada and the Indian community of Manitoba.** This working level activity must be supported by adequate and relevant health research and planning. To ensure it is truly tripartite in nature, the Indian representation must be sufficiently resourced to allow development and maintenance of their legitimate role.

5. That the two governments meet quickly to review, evaluate and renegotiate the Memorandum of Agreement of 1964, between Manitoba and Canada, on services to non-Indians living adjacent to reserve (and other) communities where the Federal government provides most health services and on services to Indians living adjacent to (or in) communities where the Province provides health services.

To this end, and to ensure a continuity in the communication required of all of the parties involved, the Subcommittee further recommends:

6. That there should be one "Tripartite Committee" concerned with health and health related matters involving the Federal and Provincial Governments and the Indian community of Manitoba. This Committee should, in the interest of efficiency and effectiveness, be small, functional, and empowered to make both recommendations and decisions at the most senior level.

7. That joint endeavours such as common environmental services (design, construction, maintenance, inspection), shared training and orientation programs for health personnel and health demonstration projects should be considered for implementation as soon as feasible.

8. That insofar as it is reasonably possible, all northern and isolated communities should receive uniformly good health care, both as it relates to those services traditionally known as insured services and as it relates to uninsured services. Of early concern to the Tripartite Committee, referred to in Recommendation 6, should be a clarification of the provision of uninsured services to persons of Indian status. These would include: home care services, including necessary equipment and therapy, alcohol and drug treatment, institutional care for incapacitated elderly, chronically ill or severely disabled persons and the provision of support and rehabilitation services to persons with disability.

Manpower and Education

Manpower in this discussion includes all those individuals involved in the provision of health care to Indians and Inuit. As such, it involves doctors, nurses, administrators, community health workers and other professionals, paraprofessionals and auxiliaries at various levels. The goal for such individuals is that they be accessible, responsive to the communities' needs and effective.

Outside of traditional health services and practices, the health care services provided in Indian communities are largely conceived, planned, organized, delivered, funded and evaluated by non-Indians. Non-Indians are generally the health care providers. Some 300 Indians in Canada are professionally trained as nurses; fewer than a dozen are qualified as physicians. There are larger numbers of Indian auxiliary workers and staff, for example there are about 700 Community Health Representatives in Canada, but these auxiliary personnel, while important participants in the health care team, are generally not the health care program planners.

Within the system as it stands, there are chronic difficulties in recruiting and retaining qualified professionals. This is not unlike the problem encountered in other rural areas, where the isolation from specialized technology, and the lack of the social amenities and comforts of urban life, act as strong disincentives to employment. The problem is compounded by the cultural and communication barriers between Indians and non-Indians in native communities. Non-Indians entering such communities are seldom prepared in a professional or social sense to handle this often complex situation.

Partial responsibility for this rests with the inappropriate training and orientation of individual health providers prior to such employment. The high technology approaches taught in medical and nursing schools are often inappropriate in small isolated communities. The necessary community and preventive skills are often lacking. Nurses trained to work in supervised hospital settings are often expected to act as independent practitioners in isolated areas, without the support systems that most physicians have and depend upon. At the same time, even the most knowledgeable, persistent and sensitive health care provider can be thwarted by community barriers and the often negative perceptions and lack of health care knowledge of health care recipients. The recipients, in turn, have considerable difficulties imposed upon them by the providers' lack of knowledge and insensitivity to community values and culture.

The difficulty with recruitment and retention and thus with continuity of care is obvious when one looks at both the high vacancy and underfill rates for positions in isolated locations. The average length of stay of nurses and doctors, whether with Medical Services Branch or the Northern Medical Unit of the University of Manitoba, is only 18 months.

The situation may be changing in that Manitoba is tending recently to hold onto its own medical graduates, as the job market tightens elsewhere. There also appears to be less of a problem recruiting rural physicians as urban opportunities are filled. Changes in the rules governing immigration have all but removed the United Kingdom and Ireland from being traditional sources of physicians for Canada's northern and rural areas. This loss may be negatively offsetting the gain in the expected trickling of surplus 'urban' physicians into northern and remote areas.

The reasons for leaving employment in the north and in isolated communities are complex. There are those of a professional nature, such as the desire for further education or advancement, or for contact with colleagues. There are also those of a more personal nature, such as family relocation, inadequate living conditions and cultural isolation. These issues have been and will continue to be addressed by those involved (Medical Services, the Province, the Northern Medical Unit, and the communities). There are attempts to create opportunities for continued education within employment situations, to form specific training programs for those working in the north, to improve orientation to the communities, and to improve both the living facilities and the financial benefits.

The Provincial Standing Committee on Medical Manpower is encouraging rural practice by offering incentive grants to those locating in underserviced areas, and special loans to medical students willing to go to such areas upon graduation. The Faculty of Medicine is providing more opportunities to medical students to go to rural and northern areas for electives and summer work experiences, and attempts are made to give increased exposure to community medicine and native health issues.

Increased Indian involvement and control might solve some of the manpower problems. As well, control of recruitment programs would increase the communities' understanding of and sensitivity to the needs of health professionals. Recruitment and retention, communication and responsiveness to the needs of the community could likely be improved with the employment of more Indians. With cultural barriers decreased, Indian employees would perhaps be in a better position than non-Indians to react to community needs and changes.

Over recent years, there have been increasing numbers of Indians entering health care employment. In isolated locations, Indian staff have long had important ancillary roles such as health and clinic aides, nursing station caretakers, etc.

In 1960, the Government of Canada launched a training program for Community Health Representatives. Other programs for alcoholism counsellors and mental health workers, x-ray technicians, dental therapists and environmental health aides have also been set up over the intervening years. More recently, programs which have enabled Indian students to more readily access regular training in professional areas, including law, education, social work, nursing, dentistry, medicine and pharmacy have gained prominance. The Special Premedical Studies Program at the University of Manitoba deserves particular mention in this regard.

The issue of self-control highlights another manpower need; the need for skilled health administrators. The ability to plan, to evaluate, to allocate and manage resources is fundamental to any effective health care system. Until such skills are present at the local and regional level, there is little likelihood of effective Indian control. This need not, however, preclude or delay the transfer of control over health services; management services can be purchased. It does highlight an important future manpower need.

A long standing and unsettled question is the relative priority that should be given to training professionals as opposed to training paraprofessionals or lay health workers. On the one hand, it is not always feasible or even desirable to have the most highly trained professionals working in small isolated communities. For example, it is generally accepted that nurses are the most appropriate primary care givers in most isolated communities. It is also often argued that the key to change is at the grassroots and/or paraprofessional level, (using community individuals with only basic health training as primary care providers). Others feel that the presence in a community of a physician enhances the self-image and reduces the anxiety of the community. However resolved, the training must be appropriate to the job at hand, and a functional and easily accessible support system must be in place.

While recognizing that many problems and issues are interrelated and that progress will wait for positive action on several fronts, the Subcommittee recommends:

1. **That Indians and Inuit be involved with the Provincial and the Federal Government in setting priorities for native health-related training programs, (professional, paraprofessional, administrative), in order that these programs be more responsive to the needs of Indian and Inuit communities.**

2. **That the Provincial and Federal Governments seek ways to increase training opportunities to enable Indians to assume responsibilities as health program planners, hospital and clinic administrators and health organization managers as well as continuing current health professional and auxiliary career training programs.**

3. **That local communities be involved in the recruitment, selection and retention of health personnel.**

4. **That all health personnel be oriented to their role and responsibilities in isolated and cross-cultural settings. The orientation should include job function and individual role in services to the community, orientation to the community and expectations of the community. The community should be involved in this orientation, making it equally an orientation of the community to the health care providers and health system as well.**

5. **That the Federal and Provincial Governments and the health professional licencing associations involved recognize and deal with the continuing need for nurse practitioners to work in isolated locations. Their role, training, qualifications and certification must be clearly established.**

6. **That a course to train nurse practitioners for work in isolated locations be developed by an institution designated by the Tripartite Committee, and that this course development and training endeavour be supported by both governments with specific resource allocations.**

Planning and Regionalization

The need for overall planning for health care services is recognized at both the provincial and national levels. The problems inherent in the current system of "laisse-faire" arrangements operating within very broad legislative or political mandates are seemingly augmented in the case of rural and isolated communities. With Indian communities the issues of adequate long-term funding, sufficient and appropriately trained and skilled health manpower, patient referral and transportation arrangements and jurisdictional questions arising between governments, professions and recipients become more pronounced. In part, this is because of social, economic and environmental factors and the presence of a separate federal health service.

The issues of patient referrals and medical evacuations are closely related to planning. Increasing numbers of patients are referred out of Indian and northern communities to receive more specialized care as the result of the perception on the part of the patient or health care provider of inadequate local resources and facilities (real or unreal). In part this increase in patient referrals and evacuations can be attributed to efforts by both federal and provincial governments to ensure that people in isolated communities have the opportunity to access programs and care options available to the populations of larger centres.

On the other side of the ledger, there are negative facets in this trend toward more centralized patient care. Firstly, there is the social disruption to the individual and family created by his or her absence and by the alienation often experienced outside the community. Secondly, there is the growing financial cost of such activities. The patient transportation costs of Medical Services Branch grew from $2.7 to $4.7 million in the last five years. The cost to the Province of its Northern Patient Transportation Program (N.P.T.P.) is likewise climbing, (from $1.2 to $2.5 million over 5 years) as are the number of insured benefit payments created by the referrals. Lastly, but importantly, with much of the health care provided outside the local community, a loss of local control and understanding occurs and increased dependency seems to result.

Changes in local facilities, the lack of effective or appropriate controls, improved standards for care, staff and access, the desire for alternative sources of care and the ready availability of improved transportation have all contributed to this increase in the removal of patients for care in larger centres. There is no evidence, however, that any improvements in the health status of Indians can be attibuted to these efforts.

If health care services can be made more effective, responsive and economically efficient, then one means of achieving that aim is likely through the organization of services on a regional basis. This would allow substantial control and responsibility, and consequently initiative, to be vested with the consumers of the services who would in turn be directly accountable for its successes and its excesses. For example, if the referral system and transportation were coupled with local control, both providers and recipients would have some incentive to accept responsibility for rationalizing the current system.

The Subcommittee was not able, in the time available to it, to outline the basis for an overall health plan. It does make the following recommendations:

1. **That a planning process be developed to direct the ongoing development, coordination and operation of health services in rural and northern areas, particularly as those services impact on populations at special risk; e.g. Indians, elderly.**

   That this include:

   1.1 Cooperation and close consultation in the planning process between all levels of government, providers, recipients and relevant organizations.

   1.2 Review of and amendments to relevant federal and provincial legislation so as to allow for the full and equitable participation of Indians in the planning, operation and governance of health care programs and institutions. This should include representation on the governing boards of hospitals with representation based on the population in the hospital catchment area.

   Larger regional hospitals (e.g. Brandon, Dauphin, The Pas, Thompson) have special wide-area responsibilities beyond those assumed by local or municipal facilities. The Board structure and organization of regional hospitals and regional services should reflect this regional responsibility, and regional representation, (perhaps going beyond the immediate 'catchment area') should be directed by law.

1.3 Development of a comprehensive, accurate and consistently compatible and comparable data base on health status, costs and utilization through cooperation between the Federal and Provincial Governments.

1.4 An examination of the potential advantages of various forms of regionalization, particularly in difficult to serve areas with small and widely dispersed communities and populations.

1.5 An examination of the advantages of community, district or regional level health maintenance organizations as alternative patterns to current modes of individual and community health care.

2. That the Provincial Northern Patient Transportation Program and the Federal Medical Services Branch Transportation Program be reviewed and evaluated to expressly determine if economies might be realized. Referral patterns should be monitored by all agencies providing services and where significant deviations from norms are found, explanations should be sought and corrective action, including possible education of all providers and recipients, taken.

Research and Evaluation

The area of "research" in native health brings forth many questions - Should such research be encouraged? If so, what should the priorities be and who should set them? Who should be involved in the research work and by what process? There are many political and ethical issues raised by these questions.

In attempting to answer the first question, one has only to look at the health status of Indians and the many unanswered questions in this area. Indians themselves want answers and have set such priorities as mental and environmental health, usually emphasizing "applied research". They ask questions like; "What are the real health needs of our people and how can we most effectively deal with them?" There are many causes of morbidity and mortality that are poorly understood and many areas where interventions and programs are of uncertain efficacy.

It cannot be assumed that creative thinking and the right questions will be asked by researchers working on their own, quite isolated from both subjects and those who will use research results. It is now realized that a new pattern of cooperation is needed between those who will conduct the studies and those who will use the results.

The Subcommittee recommends:

1. **That specific mechanisms be developed through the Tripartite Committee to facilitate Indian involvement and participation at all levels of research and evaluation activities in Indian communities. The Northern Health Research Unit being developed at the University of Manitoba illustrates one such mechanism.**

2. **That priority be put on a systems approach to health research, looking not only at the influences of medical intervention, but at environment, education, lifestyle and sociocultural factors. Research on health service delivery systems, recipient attitudes and urban migration will be essential in the development of effective health care programs. Various medical conditions can be identified as demanding specific attention. These include meningitis, otitis media, mental health and dental caries.**

3. **That funding agencies be asked to identify specific funds available for research related to Indian health and health services and to involve Indians in the allocation of these funds.**

A significant hindrance to the work of the Subcommittee and a concern to most Subcommittee members in their own work was the lack of sufficiently current and useful data on the Indian population of Manitoba, the Inuit of the Keewatin area of the Northwest Territories and the residents of northern and isolated areas in general. What data were available from federal and provincial sources lacked utility as common definitions were often not used, aggregates were not readily comparable, health indicators were not always uniformly described or recorded, sub-groups within communities were not generally identified or tracked, and geographic boundaries were differentially defined both between jurisdictions and over time.

Data are collected and maintained for program and activity monitoring, reporting and planning functions by separate bureaus and generally for their own internal reasons. As a consequence, health status is difficult to assess except by gross indicators and for limited groups of the populations of concern to researchers, health care providers and planners, political authorities and others. Information that could be usefully used to do effective longitudinal studies, cost-benefit comparisons, program evaluation, trend analysis and truly consistent reviews of morbidity and mortality is not readily available, if at all. What information there is generally comprises only a "snapshot" of what needs to be known.

While the Subcommittee placed a high degree of priority on the need for a truly functional data base, there was also a recognition that new resources were not necessarily available or needed to achieve this objective. It was the general impression of Subcommittee members that there were sufficient data resources maintained by the various organizations involved. Cooperative data streamlining, rationalization and sharing could do much to meet this critical information requirement of governments, providers and recipients.

The Subcommittee recommends:

1. **That improved information systems be developed to ensure that accurate, timely and complete health status and health care data are available by age, sex, residence, community and region, cross-indexed to relevant indicators.**

2. That the information so gathered should be made available on an annual basis in a format agreed to by the Governments of Canada (Health and Welfare, Medical Services Branch) and of Manitoba (Manitoba Health Services Commission).

3. That professional associations, governing and licencing bodies be asked to develop audit and evaluation standards and systems to enable review of community, out-patient and non-facility ambulatory care and practice. (This should include physician, and in nursing stations, nursing practice.)

4. That there be a specific examination of the utilization of hospital outpatient and emergency clinics by Indian and non-status native peoples, the resulting and contributing patterns of service selection, care seeking and treatment.

5. That any new program, demonstration or pilot project, whether government or community-based, have built in an evaluation component with the necessary design and funding to support such a review effort.

SPECIAL CASES

Urban Native Health

At present, there is a great gap in knowledge pertaining to the health status of Indians and non-status natives in urban areas. There is sufficient information to know that this group is growing, is at high risk, and as such will be placing greater demands on urban health services, (Appendix 3, a-d). It is also known that some 10% of recent native migrants to Winnipeg listed their reasons as being medical in nature. This result was about the same for both Status Indians and Metis/Non-Status Indians. (6)

The Subcommittee recommends:

1. **That there be a survey of the native population in Manitoba's urban centres, particularly Winnipeg, to determine the population (in Winnipeg by district), and the in and out migration of individuals and families, including where those people are migrating from and to, and why. Information on age, sex, family size, employment, income, education and whether or not the migrants have Indian status will also be important. Assuming the expense of a full census is beyond current financial resources, a carefully constructed and implemented survey involving selected samples could provide adequate data at reasonable cost. This survey should:**

   1.1 be a joint endeavour of the Governments of Manitoba and Canada; the City or municipal authority; and urban, regional and provincial Indian and Metis organizations, and be coordinated by the Tripartite Committee.

   1.2 include Brandon, Dauphin, Flin Flon, Portage la Prairie, Selkirk, Swan River, The Pas, Thompson and Winnipeg.

   1.3 examine all forms of accommodation; social, cultural and economic supports; health status; health needs; health attitudes, perceptions and beliefs; health behaviour; where and when services are sought and found and how they are accessed; current illness patterns and outcomes; allied health and social services (eg. home care, rehabilitation, economic assistance); and problems of access, language and interpretation,

cultural barriers and discrimination, as well as why the 'subject' has moved to, lives in or has left or is leaving the urban centre.

1.4 review and report on health and related services available to migrants; the providers and facilities - both private and public; and the perceptions of recipient communities and individuals.

Northwest Territories

The Keewatin area of the Northwest Territories covers an area of approximately 70,000 square miles and has a population of approximately 5500, mainly Inuit.

Health services to the Keewatin District are provided by the Government of Canada, Medical Services Branch within arrangements increasingly involving the Government of the Northwest Territories, Department of Health. The University of Manitoba, Faculties of Medicine and Dentistry through the Northern Medical Unit and the Northern Dental Unit have a very immediate role in providing front-line medical and dental services, back up specialist support and consultation. Manitoba (Churchill and Winnipeg) health care facilities provide secondary and tertiary levels of care not available in the Nursing Stations of the Keewatin.

The Subcommittee considered numerous issues, particularly those impacting on the predominantly Inuit residents of the Keewatin. Representation from the Government of the Northwest Territories described the existing services as adequate in terms of quality and accessibility. Political developments in the Northwest Territories have raised the possibility of reduced future health services use of the Churchill Health Centre, which in turn leads to some question about the future viability of Churchill.

Concerns focused on interpreter services for Inuit at secondary and tertiary hospital facilities. In spite of extensive existing programming, there is a perceived lack of service by Inuit patients. A similar concern was expressed regarding accommodations for patients in transit. A more profound concern expressed by many Inuit relates to the status of the children born in Manitoba hospitals without Northwest Territories 'citizenship'. The concern relates to both cultural and political identity as well as to the effect of a Manitoba birth certificate in the consideration of benefits accruing to Northwest Territories Inuit relevant to land claims.

These and other concerns have resulted in the Keewatin Inuit Association requesting the establishment of a Health Commission to review health services in the Keewatin, and in other sites specific to Inuit patients.

The Subcommittee makes the following recommendations relative to services in or directed to the Keewatin:

1. That in view of the very real problems in communication between Inuit patients and non-Inuit health care providers, there should be programs to improve the quality of interpreting, to upgrade the skills of current interpreters and to increase the number of trained interpreters, (in Churchill and Winnipeg).

2. That due to the many breakdowns in communications between patients, nursing station staff, consultants and other care providers, health facilities and transportation agencies, there should be efforts made to improve the communication between and the coordination of all components of the health system and better integrate services with community expectations.

3. That meningitis, otitis media, dental caries and mental health, (as noted elsewhere), be identified as concerns requiring a major thrust in basic science and applied reasearch.

4. That the proposal of the Keewatin Inuit Association to have an Inuit Health Commission review health services in the Keewatin be supported.

5. That there be improvements made in out-of-hospital accommodations available to Inuit patients in Churchill and Winnipeg.

6. That there be increased Inuit involvement in the planning, organization and delivery of health services in the Keewatin or affecting Keewatin Inuit patients.

7. That consideration be given by the Governments of Manitoba and Canada to the possibility of designating a part of the Churchill Health Centre and the Women's Hospital in Winnipeg as belonging to the Northwest Territories, for the delivery of Inuit babies, in order that Inuit born in Churchill and Winnipeg can have the comfort of

being born in the Northwest Territories, "in their land".

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TABLE 1

Standardized Morbidity Ratios of Manitoba Status Indians

Disease	Discrete Patients SMR*	Hospitalizations SMR*
Infectious Diseases	4.27	4.70
Neoplasms	0.73	0.81
Endocrine	3.91	4.22
Blood	3.13	2.75
Mental Disorders	2.50	2.46
Neurology	2.65	2.86
Cardiovascular	1.83	2.06
Respiratory	3.03	4.00
Digestive	2.18	2.46
Genito-Urinary	2.18	2.27
Ectopic & Molar Pregnancy	2.01	2.02
Normal Delivery	2.28	2.33
Complications Pregnancy	3.91	4.31
Skin	6.12	6.51
Musculo Skeletal	1.11	1.17
Congenital Anomalies	1.20	1.24
Perinatal Conditions	1.89	1.92
Symptoms, Signs	2.55	2.60
Accidents, Violence	3.33	3.64
Factors Influencing Health	1.92	1.83

* S.M.R.: Standardized morbidity ratio = $\frac{\text{rate of hospitalization in Manitoba Status Indians}}{\text{rate of hospitalization in general Manitoba population}}$

Source: M.H.S.C. data 1981-82

TABLE 2

New Cases and Reactivations of Tuberculosis

	NEW CASES			REACTIVATIONS		
	*All Cases	Status Indians	Total	*All Cases	Status Indians	Total
1961	169	56	255	41	19	60
1966	160	54	214	32	14	46
1972	126	49	175	20	10	30
1973	137	45	182	28	8	36
1974	153	76	229	18	13	31
1975	104	41	145	18	6	24
1976	124	39	163	12	7	19
1977	98	47	145	12	2	14
1978	113	46	159	13	5	18
1979	105	53	158	10	9	19
1980	114	34	148	12	12	24
1981	104	30	134	9	9	18
1982	84	49	133	16	5	21
1983	109	86	195	6	7	13

Note: Manitoba Status Indian Population
1982 (December 31) 49,956
1983 (June 21) 50,637
(Medical Services Branch Population Figures)

From 1983 Annual Report, Sanatorium Board of Manitoba

TABLE 3

Hospitalizations for Infectious Diseases in Manitoba Status Indians

	Discrete Patients SMR
001-139 Infectious Diseases	4.27
001-009 Intestinal	4.97
555-558 Non-Inf. Enteritis	3.69
010-018 Tuberculosis	23.75
460-466 Acute U.R.I.	5.09
480-487 Pneumonia	6.71
680-686 Skin Infections	6.82
614-616 Pelvic Inflammatory Disease	2.93
CNS Infection	3.26
Appendicitis	1.26

$$\text{S.M.R.} = \frac{\text{Number of Individual Manitoba Status Indians hospitalized}}{\text{Number of Individual Manitoba Residents (total) hospitalized}}$$

Source: M.H.S.C. data 1981-82

TABLE 4

MANITOBA STATUS INDIAN HOSPITAL UTILIZATION SUMMARY, 1983/84*
PATIENT DAYS PER 1000 POPULATION
BY REGION OF RESIDENCE AND AGE GROUPS

REGION	Under Age 1	1 to 9	10 to 17	18 to 34	35 to 54	55 to 64	65 to 74	75+	All Ages, Status Indians	All Ages, Residents Other Than Status Indians **
CENTRAL	8,336	1,204	616	1,357	2,165	5,776	9,290	9,703	1,888	1,506
EASTMAN	13,646	1,464	775	1,462	2,065	5,009	4,581	10,256	2,132	1,286
INTERLAKE	3,112	614	407	1,489	1,526	5,076	5,903	14,775	1,616	1,350
NORMAN	7,100	1,005	799	1,726	1,699	2,493	6,357	9,843	1,768	1,429
PARKLAND	29,554	4,673	1,029	1,381	1,612	3,582	7,493	16,059	3,644	2,045
WESTMAN	13,552	1,749	709	1,495	1,684	5,360	6,412	13,628	2,120	2,103
WINNIPEG	4,194	793	519	1,596	2,232	3,745	18,560	2,538	1,578	1,459
MANITOBA STATUS INDIANS	8,695	1,253	710	1,588	1,823	3,746	7,228	10,895	1,897	1,543
All Manitoba Residents (Includes Status Indians)***	2,047	353	335	721	868	2,065	4,415	11,194	1,550	

* Source: M.H.S.C. Hospital Report No. E44746 GRPT.
** Source: M.H.S.C. Hospital Report No. E446FRPT2.
*** Source: M.H.S.C. Hospital Report No. E447ERPT.

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TABLE 5

STATUS INDIAN HOSPITAL UTILIZATION
BY REGION OF RESIDENCE AND REGION OF HOSPITALIZATION, 1983/84
(ALL DIAGNOSES, ALL AGES)

Region of Residence (By Mailing Address)	Pop. June, 1983	SAME REGION (RURAL) HOSPITALIZATION				TRANSFER* TO WINNIPEG HOSPITALS				TRANSFER* TO OTHER REGIONS AND OUT-OF-PROVINCE				TOTAL UTILIZATION			
		Cases	Patient Days	Cases/ 1000 Pop.	Days/ 1000 Pop.	Cases	Pat. Days	Cases/ 1000 Pop.	Days/ 1000 Pop.	Cases	Days	Cases/ 1000 Pop.	Days/ 1000 Pop.	Cases	Days	Cases/ 1000 Pop.	Days/ 1000 Pop.
CENTRAL	3,205	792	3,761	247	1,173	127	1,142	40	356	170	1,215	53	379	1,089	6,118	340	1,909
EASTMAN	5,895	1,299	5,748	220	975	588	5,358	100	909	295	1,405	50	238	2,182	12,511	370	2,122
INTERLAKE	5,235	753	3,472	144	663	548	4,597	105	878	98	425	19	81	1,399	8,494	267	1,623
NORMAN	20,928	4,802	22,399	229	1,070	1,558	13,784	74	659	220	1,144	11	55	6,580	37,327	314	1,784
PARKLAND	2,562	1,240	7,451	484	2,908	102	1,152	40	450	212	841	83	328	1,554	9,444	607	3,686
WESTMAN	2,818	926	4,937	329	1,752	89	841	32	298	61	240	22	85	1,076	6,018	382	2,136
WINNIPEG	6,970	0	0	0	0	1,225	9,346	176	1,341	452	2,046	65	294	1,677	11,392	241	1,634
MANITOBA	47,613	9,812	47,768	241**	1,175**	4,237	36,220	89	761	1,508	7,316	32	154	15,557	91,304	327	1,918

SOURCE: M.H.S.C. REPORT NO. E44746FRPT2

*** Transfers include self-referrals,**

**** Ratio is calculated with rural population sub-total of 40,643, excluding 6,970 in Winnipeg.**

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TABLE 6

MANITOBA HOSPITAL UTILIZATION, ALL RESIDENTS OTHER THAN STATUS INDIANS, BY REGION OF RESIDENCE AND REGION OF HOSPITALIZATION, 1983/84 (ALL DIAGNOSES, ALL AGES)

Region of Residence	Pop. June, 1983	SAME REGION (RURAL) HOSPITALIZATION				TRANSFER* TO WINNIPEG HOSPITALS				TRANSFER* TO OTHER REGIONS AND OUT-OF-PROVINCE				TOTAL UTILIZATION			
		Cases	Patient Days	Cases/ 1000 Pop.	Days/ 1000 Pop.	Cases	Pat. Days	Cases/ 1000 Pop.	Days/ 1000 Pop.	Cases	Days	Cases/ 1000 Pop.	Days/ 1000 Pop.	Cases	Days	Cases/ 1000 Pop.	Days/ 1000 Pop.
CENTRAL	87,806	9,933	88,948	113	1,013	3,605	36,913	41	420	920	6,404	10	73	14,458	132,265	165	1,506
EASTMAN	69,665	5,726	46,423	82	666	4,138	37,662	59	541	615	5,496	9	79	10,479	89,581	150	1,286
INTERLAKE	61,462	4,315	37,981	70	618	3,750	42,687	61	695	336	2,325	5	38	8,401	82,993	137	1,350
NORMAN	53,488	8,231	45,139	154	844	2,020	21,014	38	393	1,754	10,284	33	192	12,005	76,457	224	1,429
PARKLAND	47,534	7,229	66,043	152	1,390	1,253	14,858	26	313	2,026	16,291	43	343	10,508	97,194	221	2,045
WESTMAN	117,185	18,712	217,257	160	1,854	1,966	21,749	17	186	974	7,440	8	63	21,632	246,446	185	2,103
WINNIPEG	603,536	0	0	0	0	65,436	855,624	108	1,418	3,365	24,745	6	41	68,801	880,369	114	1,459
MANITOBA	1,040,676	54,146	501,813	124**	1,148**	82,168	1,030,507	79	990	9,990	72,985	10	70	146,284	1,605,305	141	1,543

Source: M.H.S.C. REPORT NO. EA4746PBPT2 (Excludes 67,613 Status Indians).

* Transfers include self-referrals, direct admission in Winnipeg hospitals, and inter-hospital transfers.

** Ratio is calculated with the rural population sub-total of 437,140, excluding 603,536 in Winnipeg.

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TABLE 7

MANITOBA HOSPITAL UTILIZATION,
PATIENT DAYS PER 1000 POPULATION,
STATUS INDIANS AND OTHER RESIDENTS,
BY REGION OF RESIDENCE AND REGION OF HOSPITALIZATION, 1983/84
(ALL DIAGNOSES, ALL AGES)

REGION OF RESIDENCE	SAME REGION (RURAL) HOSPITALIZATION		TRANSFER* TO WINNIPEG HOSPITALS		TRANSFER* TO OTHER REGIONS AND OUT-OF-PROVINCE		TOTAL PATIENT DAYS PER 1000 POPULATION	
	STATUS INDIANS	OTHER RESIDENTS	STATUS INDIANS	OTHER RESIDENTS	STATUS INDIANS	OTHER RESIDENTS	STATUS INDIANS	OTHER RESIDENTS
CENTRAL	1,173	1,013	356	420	379	73	1,909	1,506
EASTMAN	975	666	909	541	238	79	2,122	1,286
INTERLAKE	663	618	878	695	81	38	1,623	1,350
NORMAN	1,070	844	659	393	55	192	1,784	1,429
PARKLAND	2,908	1,390	450	313	328	343	3,686	2,045
WESTMAN	1,752	1,854	298	186	85	63	2,136	2,103
WINNIPEG	0	0	1,341	1,418	294	41	1,634	1,459
MANITOBA	1,175**	1,148**	761	990	154	70	1,918	1,543

Source: M.H.S.C. Report No. E44746FRPT2.

* Transfers include self-referrals, direct admission in Winnipeg Hospitals, and inter-hospital transfers.

** Ratio is calculated with the rural population sub-total, excluding Winnipeg's population.

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TABLE 8

M.H.S.C. STATUS INDIAN MEDICAL UTILIZATION
BY REGION OF RESIDENCE AND REGION OF SERVICE DELIVERY, 1983/84
(ALL DIAGNOSIS, ALL AGES)

Region of Residence (By Mailing Address)	Pop. June, 1983	SAME REGION (RURAL) SERVICE DELIVERY				WINNIPEG SERVICE DELIVERY				OTHER REGIONS AND OUT-OF-PROVINCE DELIVERY				TOTAL MEDICAL UTILIZATION			
		Patients	Cost	Cost Per Patient	Per Capita Cost	Patients	Cost	Cost Per Patient	Per Capita Cost	Patients	Cost	Cost Per Patient	Per Capita Cost	Discrete Patients*	Cost	Cost Per Patient	Per Capita Cost
CENTRAL	3205	2,232	$ 210,148.	$ 94.15	$ 65.57	763	$ 83,721.	$109.73	$ 26.12	920	$ 75,832.	$ 82.42	$23.66	2,836	$ 369,694.	$130.36	$115.35
EASTMAN	5895	1,972	228,032.	115.63	38.68	2,865	355,048.	123.93	60.23	759	68,811.	90.66	11.67	4,217	651,893.	154.59	110.58
INTERLAKE	5235	2,552	176,881.	69.31	33.79	3,023	386,466.	127.84	73.82	1,510	81,078.	53.69	15.49	4,416	644,427.	145.93	123.10
NORMAN	20928	11,201	1,322,827.	118.10	63.21	6,775	886,305.	130.82	42.35	2,087	151,226.	72.46	7.23	15,430	2,360,360.	152.97	112.78
PARKLAND	2562	1,840	264,008.	143.48	103.05	516	65,593.	127.12	25.60	527	58,069.	110.19	22.67	2,279	387,671.	170.11	151.32
WESTMAN	2818	2,343	310,387.	132.47	110.15	405	44,933.	110.95	15.94	189	14,887.	78.77	5.28	2,525	370,208.	146.62	131.37
WINNIPEG	6970	0	0	0	0	6,232	1,069,964.	171.69	153.51	1,723	115,579.	67.08	16.58	6,866	1,185,564.	172.67	170.09
MANITOBA	47613	22,140	2,512,285.	113.47	61.81**	20,579	2,892,034.	140.53	60.74	7,715	565,479.	73.30	11.88	38,569	5,969,800.	154.78	125.38

SOURCE: M.H.S.C. REPORT NO. E44740FRPT.

NOTE: Health & Welfare, Medical Services Branch, Medical Costs for Status Indians are excluded.

* Discrete patients are shown, avoiding double counting of patients between columns per location of service delivery.

** Ratio is calculated with rural population sub-total of 40,643, excluding 6,970 in Winnipeg.

Research and Planning Directorate
November 19, 1984
BG/lj

MANITOBA MEDICAL UTILIZATION,
ALL RESIDENTS OTHER THAN STATUS INDIANS,
BY REGION OF RESIDENCE AND REGION OF SERVICE DELIVERY, 1983/84
(ALL DIAGNOSES, ALL AGES)

Region of Residence (By Mailing Address)	Pop. June, 1983	SAME REGION (RURAL) SERVICE DELIVERY				WINNIPEG SERVICE DELIVERY				OTHER REGIONS AND OUT-OF-PROVINCE DELIVERY				TOTAL MEDICAL UTILIZATION			
		Patients	Cost	Cost Per Patient	Per Capita Cost	Patients	Cost	Cost Per Patient	Per Capita Cost	Patients	Cost	Cost Per Patient	Per Capita Cost	Discrete Patients*	Cost	Cost Per Patient	Per Capita Cost
CENTRAL	87,806	56,532	$ 5,171,441.	$ 91.48	$ 58.90	31,954	$ 4,288,187.	$134.20	$ 48.84	11,606	$ 738,257.	$63.61	$ 8.41	70,786	$ 10,197,894.	$144.07	$116.14
EASTMAN	69,663	39,334	3,513,813.	89.33	50.44	34,221	5,103,920.	149.15	73.26	5,092	363,353.	71.36	5.21	57,417	8,980,985.	156.42	128.92
INTERLAKE	61,462	37,034	3,327,064.	89.84	54.13	32,186	4,877,598.	151.54	79.36	3,258	202,279.	62.09	3.29	51,155	8,406,942.	164.34	136.78
NORMAN	53,498	37,217	4,685,720.	125.90	87.59	11,806	1,718,431.	145.56	32.12	10,422	785,455.	75.37	14.68	45,258	7,189,607.	158.86	134.39
PARKLAND	47,524	31,562	3,466,332.	109.83	72.94	6,496	1,221,842.	188.09	25.71	10,123	991,394.	97.93	20.87	38,093	5,679,769.	149.10	119.51
WESTMAN	117,185	93,652	13,431,211.	143.42	114.62	14,915	1,961,367.	131.50	16.74	8,488	543,739.	64.06	4.64	98,015	15,936,296.	162.59	135.99
WINNIPEG	603,536	0	0	0	0	516,458	104,674,365.	202.68	173.44	34,676	2,373,399.	68.45	3.93	523,032	107,047,964.	204.67	177.37
MANITOBA	1,040,676	295,331	33,595,581	113.76	76.85**	648,036	123,845,689.	191.11	119.01	83,666	5,998,471.	71.70	5.76	883,757	163,439,741.	184.94	157.05

SOURCE: M.H.S.C. REPORT NO. E44740PRPT (EXCLUDES 47,613 STATUS INDIANS).

* Discrete patients are shown, avoiding double counting of patients between columns per location of service delivery.

** Ratio is calculated with rural population sub-total of 437,140 excluding 603,536 in Winnipeg.

Research and Planning Directorate
RC/lj
November 27, 1984

Table 10
Population of Manitoba by Health Region; by Age Group and Sex
June 1, 1983

HEALTH REGION	SEX	0-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+	TOTALS
CENTRAL	M	3,897	3,753	3,829	4,287	4,119	3,585	3,100	2,724	2,186	1,976	1,976	1,994	2,008	1,816	3,670	44,920
	F	3,628	3,547	3,703	4,103	3,644	3,393	2,817	2,627	2,172	1,932	2,050	2,118	2,203	1,969	4,523	44,429
	T	7,525	7,300	7,532	8,390	7,763	6,978	5,917	5,351	4,358	3,908	4,026	4,112	4,211	3,785	8,193	89,349
EASTMAN	M	3,113	3,218	3,176	3,441	3,191	2,865	2,701	2,437	1,948	1,651	1,565	1,537	1,397	1,208	2,225	35,673
	F	2,925	3,029	3,105	3,247	2,718	2,730	2,667	2,267	1,875	1,504	1,434	1,456	1,429	1,209	2,197	33,792
	T	6,038	6,247	6,281	6,688	5,909	5,595	5,368	4,704	3,823	3,155	2,999	2,993	2,826	2,417	4,422	69,465
INTERLAKE	M	2,152	2,499	2,735	2,917	2,586	2,385	2,257	2,160	1,753	1,579	1,582	1,508	1,525	1,426	2,417	31,481
	F	2,084	2,290	2,592	2,783	2,154	2,219	2,216	2,100	1,704	1,516	1,511	1,540	1,563	1,315	2,194	[illegible]
	T	4,236	4,789	5,327	5,700	4,740	4,604	4,473	4,260	3,457	3,095	3,093	3,048	3,088	2,741	4,611	[illegible]
NORMAN	M	1,050	996	1,005	932	1,191	1,161	941	769	592	487	465	460	376	269	485	11,179
	F	916	960	931	938	1,086	1,013	885	671	525	417	416	407	357	317	525	10,364
	T	1,966	1,956	1,936	1,870	2,277	2,174	1,826	1,440	1,117	904	881	867	733	586	1,010	21,543
PARKLAND	M	1,569	1,717	1,832	2,010	1,657	1,531	1,452	1,334	1,134	1,102	1,112	1,336	1,325	1,220	2,539	22,870
	F	1,456	1,630	1,667	1,936	1,426	1,452	1,354	1,230	1,081	1,007	1,171	1,267	1,353	1,250	2,851	22,131
	T	3,025	3,347	3,499	3,946	3,083	2,983	2,806	2,564	2,215	2,109	2,283	2,603	2,678	2,470	5,390	45,001
THOMPSON	M	1,104	1,159	1,168	1,080	1,066	1,176	1,086	920	678	512	371	266	153	68	59	10,866
	F	1,078	1,057	1,099	955	1,043	1,155	991	773	566	342	275	167	131	49	68	9,749
	T	2,182	2,216	2,267	2,035	2,109	2,331	2,077	1,693	1,244	854	646	433	284	117	127	20,615
WESTMAN	M	4,350	4,469	4,484	5,007	5,220	4,747	4,062	3,501	2,845	2,627	2,911	3,079	2,958	2,853	5,675	58,788
	F	4,120	4,039	4,296	4,891	4,898	4,507	3,979	3,353	2,925	2,731	2,909	3,139	3,395	2,961	7,174	59,317
	T	8,470	8,508	8,780	9,898	10,118	9,254	8,041	6,854	5,770	5,358	5,820	6,218	6,353	5,814	12,849	118,105
WINNIPEG	M	20,965	20,297	21,761	24,005	29,899	28,788	25,231	21,271	16,066	14,342	14,504	14,016	12,808	10,988	17,678	292,619
	F	19,872	19,633	20,734	23,745	31,544	29,424	25,873	21,534	16,363	14,476	15,145	16,086	15,318	13,242	28,528	311,517
	T	40,837	39,930	42,495	47,750	61,443	58,212	51,104	42,805	32,429	28,818	29,649	30,102	28,126	[illegible]	46,206	604,136
TOTAL REGIONS	M	38,200	38,108	39,990	43,679	48,929	46,238	40,830	35,116	27,202	24,276	24,486	24,196	22,550	19,368	34,648	507,816
	F	36,079	36,185	38,127	42,598	48,513	45,893	40,782	34,555	27,211	23,925	24,911	26,180	25,749	22,252	48,560	521,520
	T	74,279	74,293	78,117	86,277	97,442	92,131	81,612	69,671	54,413	48,201	49,397	50,376	48,299	41,620	83,208	1,029,336
UNORGANIZED TERRITORIES	M	695	644	651	658	608	540	415	331	245	227	218	169	147	118	226	5,922
	F	637	610	649	669	589	520	370	235	214	222	177	138	133	96	159	5,418
	T	1,332	1,254	1,300	1,327	1,197	1,060	785	566	459	449	395	307	280	214	385	11,340
INDIAN BANDS	M	3,676	3,384	3,272	3,127	2,558	1,848	1,406	1,148	894	721	579	501	399	280	575	24,368
	F	3,499	3,142	3,291	3,048	2,581	1,851	1,340	1,041	783	647	501	413	325	270	513	23,245
	T	7,175	6,526	6,563	6,175	5,139	3,699	2,746	2,189	1,677	1,368	1,080	914	724	550	1,088	47,613
TOTAL MANITOBA	M	42,571	42,136	43,913	47,464	52,095	48,626	42,651	36,595	28,341	25,224	25,283	24,866	23,096	19,796	35,449	538,106
	F	40,215	39,937	42,067	46,315	51,683	48,264	42,492	35,831	28,208	24,794	25,589	26,731	26,207	22,618	49,232	550,183
	T	82,786	82,073	85,980	93,779	103,778	96,890	85,143	72,426	56,549	50,018	50,872	51,597	49,303	42,414	84,681	1,088,289

FIGURE 1

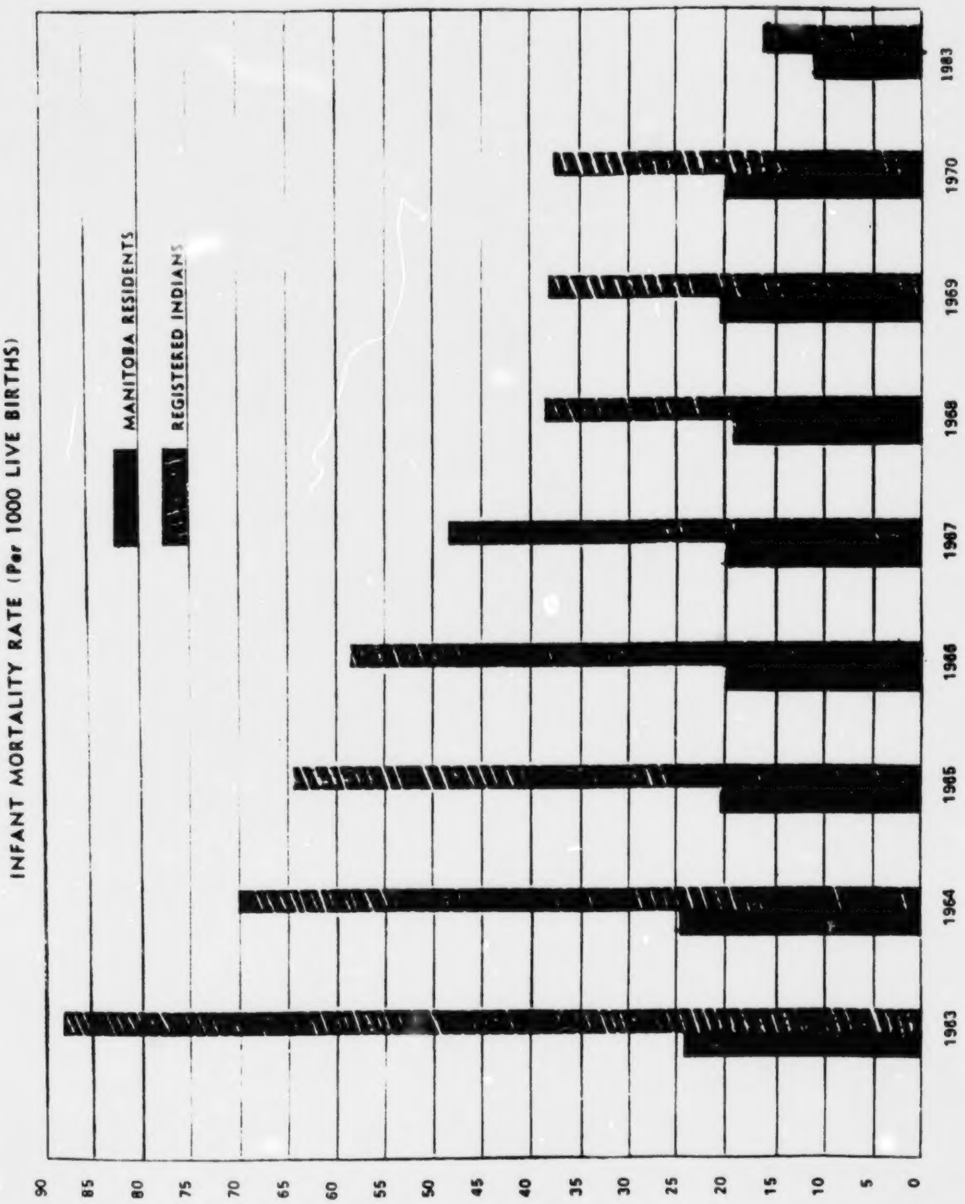


FIGURE 1

FIGURE 2

FIGURE 2

RATE OF NEW AND REACTIVATED T.B. IN MANITOBA ZONE (Per 100,000 PEOPLE)

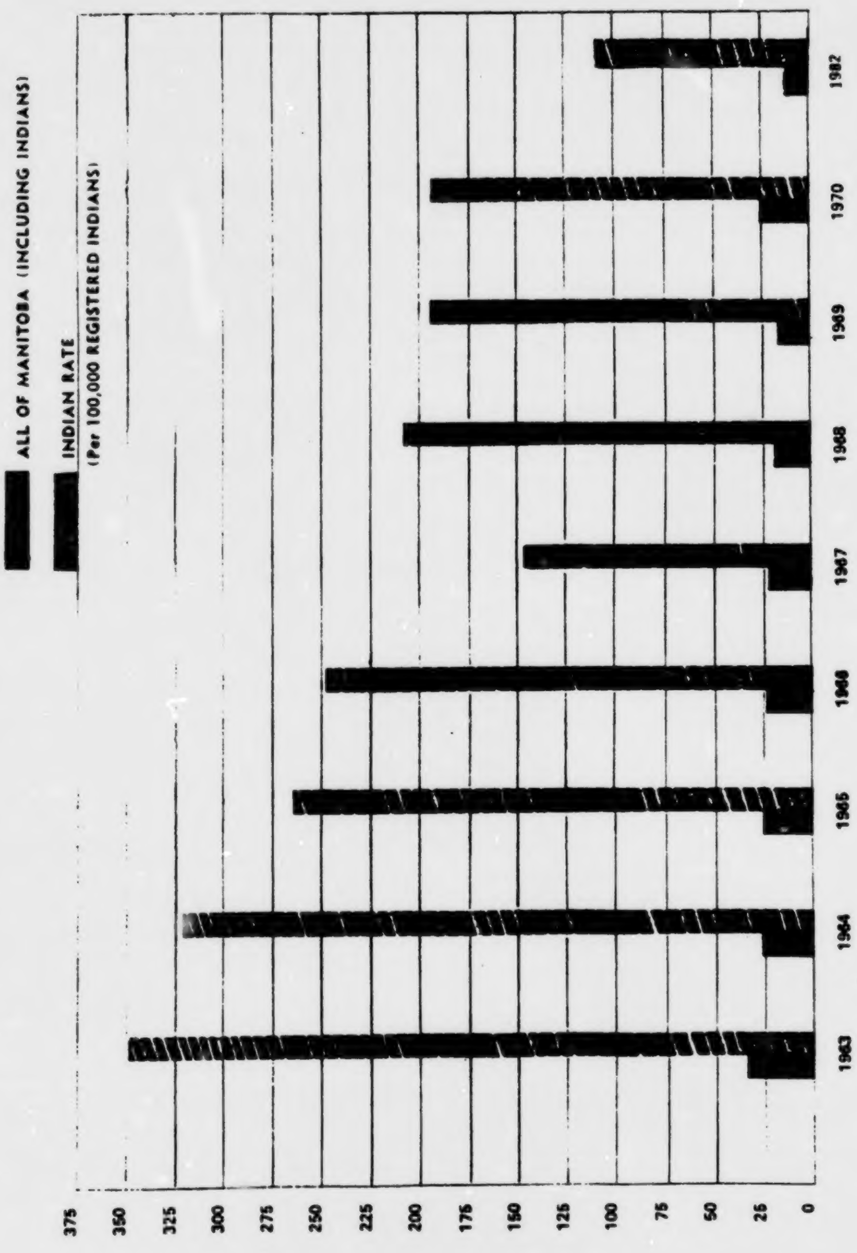
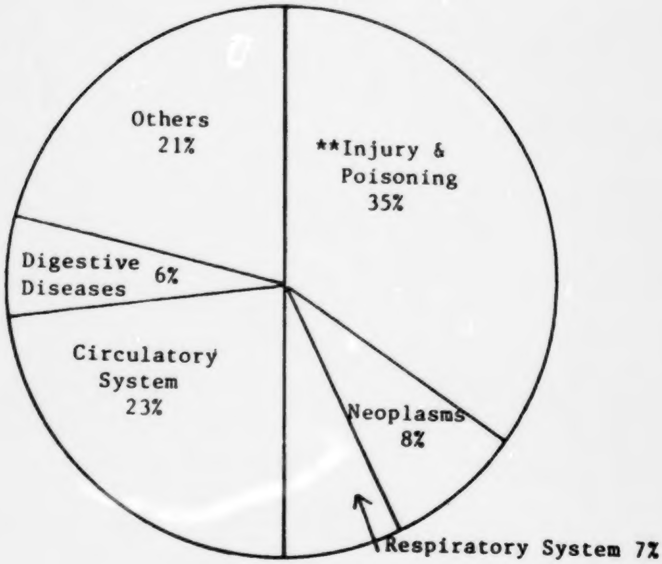


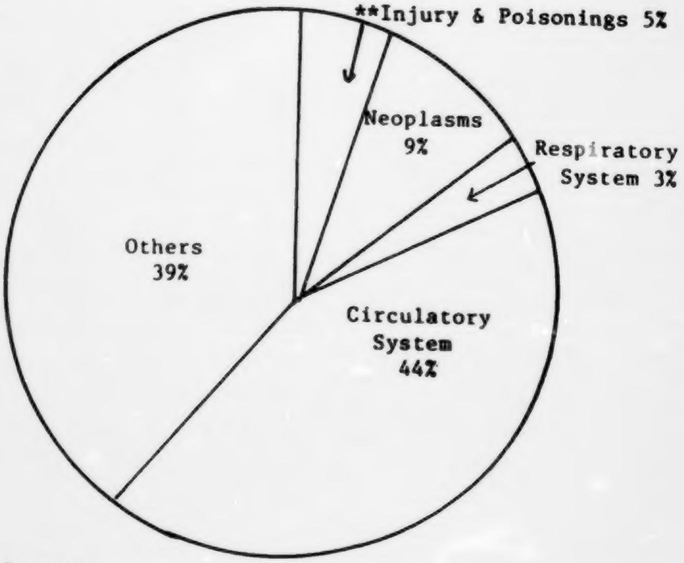
FIGURE 3

Major Causes of Death - Percentage Distribution 1979

STATUS INDIANS



* CANADA



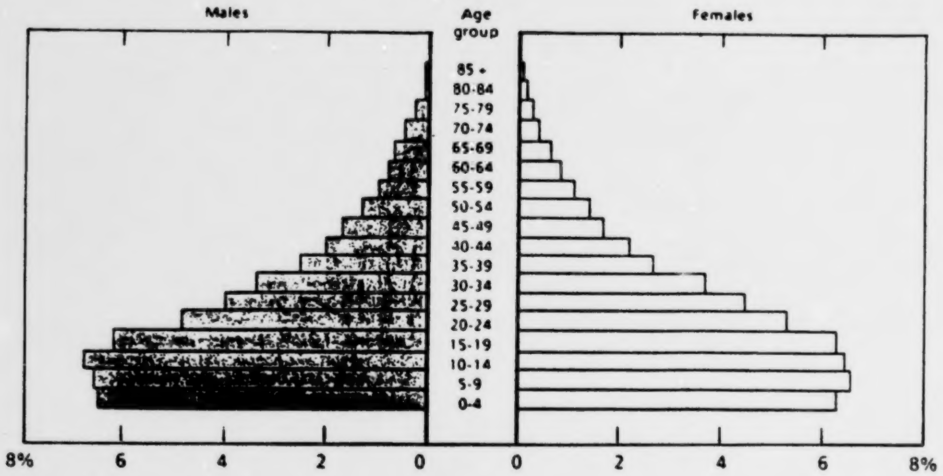
* Statistics Canada, 1978

** Injury & Poisoning (Before 1979 called Accidents, Poisoning and Violence)

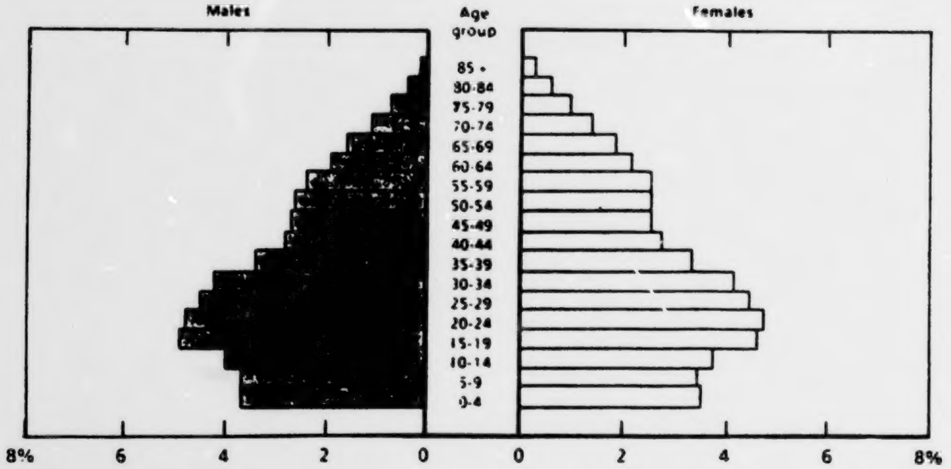
FIGURE 4

Age-sex Profile of Native People and of the Non-native Population, Canada, 1981

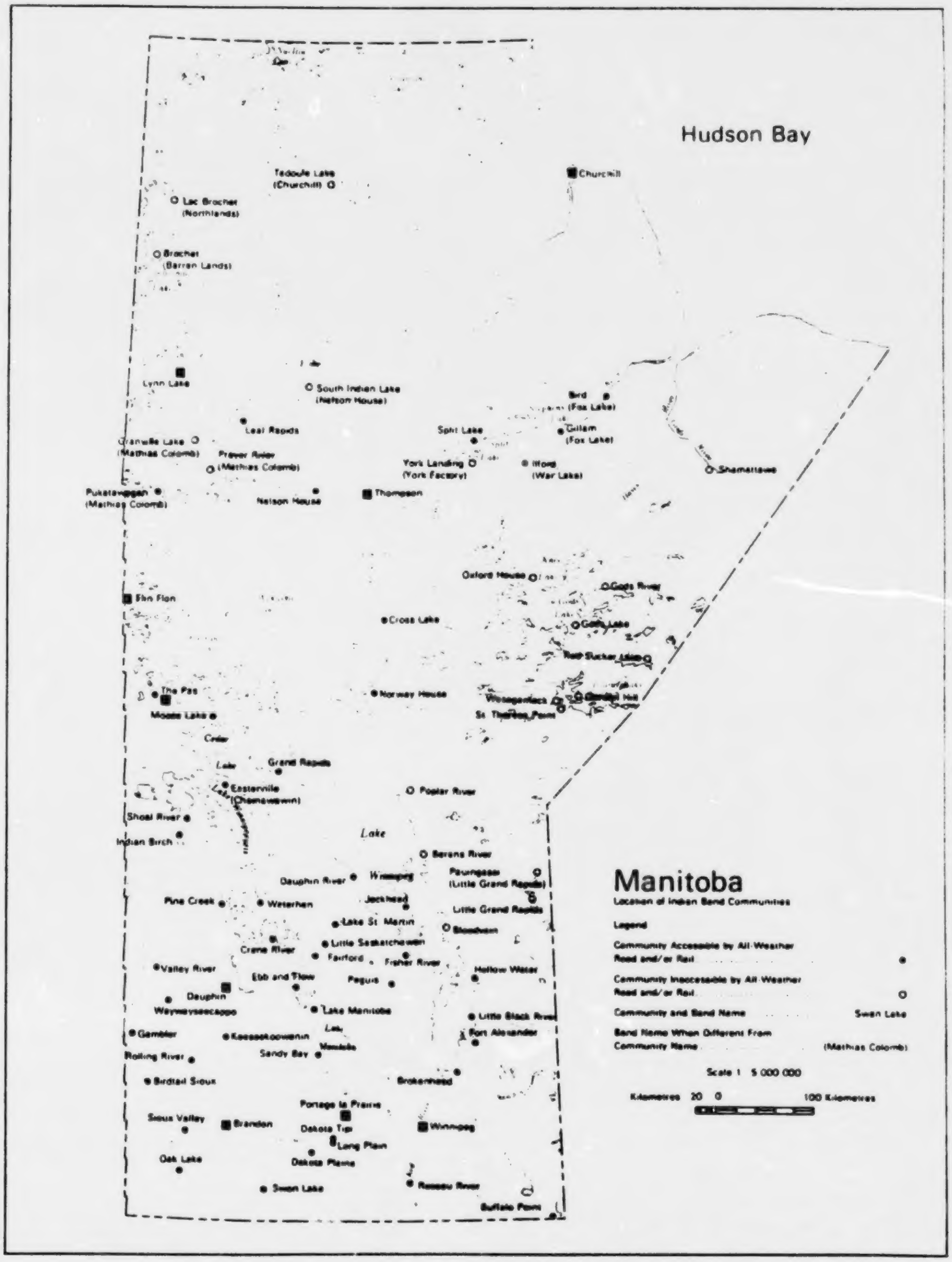
Native people



Non-native population



Source 1981 Census of Canada



Hudson Bay
Churchill
Tadoule Lake
(Churchill)
Lac Brochet
(Northlands)
Brochet
(Barren Lands)
Lynn Lake
South Indian Lake
(Nelson House)
Bird
(Fox Lake)
Gillam
(Fox Lake)
Leaf Rapids
Split Lake
Granville Lake
(Mathias Colomb)
Pranor River
(Mathias Colomb)
York Landing
(York Factory)
Ilford
(War Lake)
Shamattawa
Pukatawagan
(Mathias Colomb)
Nelson House
Thompson
Oxford House
Gods River
Flin Flon
Cross Lake
Gods Lake
Red Sucker Lake
The Pas
Norway House
Wasagamack
Garden Hill
St. Theresa Point
Moose Lake
Cedar
Lake
Grand Rapids
Easterville
(Chemawawin)
Poplar River
Shoal River
Indian Birch
Lake
Berens River
Dauphin River
Winnipeg
Paungassi
(Little Grand Rapids)
Pine Creek
Waterhen
Jackhead
Little Grand Rapids
Lake St. Martin
Bloodvein
Crane River
Little Saskatchewan
Fairford
Fisher River
Valley River
Ebb and Flow
Peguis
Hollow Water
Dauphin
Waywayseecappo
Lake Manitoba
Little Black River
Gambler
Keeseekoowenin
Lake
Manitoba
Fort Alexander
Sandy Bay
Rolling River
Birdtail Sioux
Brokenhead
Portage la Prairie
Sioux Valley
Brandon
Dakota Tipi
Winnipeg
Long Plain
Oak Lake
Dakota Plains
Swan Lake
Roseau River
Buffalo Point
Legend
Community Accessible by All-Weather Road and/or Rail ●
Community Inaccessible by All-Weather Road and/or Rail ○
Community and Band Name Swan Lake
Band Name When Different From Community Name (Mathias Colomb)
Scale 1 5 000 000
Kilometres 20 0 100 Kilometres

Manitoba

Location of Indian Band Communities

APPENDIX 1 (b)

MANITOBA REGISTERED INDIANS
POPULATION BY BAND
JUNE, 1984

SOUTH ZONE	ON-RESERVE			OFF-RESERVE			COMBINED TOTAL
	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	
Berens River	463	414	877	98	122	220	1,097
Birdtail Sioux	99	94	193	41	46	87	280
Bloodvein	245	243	488	26	49	75	563
Brokenhead	95	77	172	224	217	441	613
Buffalo Point	12	10	22	8	4	12	34
Crane River	79	81	160	37	41	78	238
Dakota Plains	48	43	91	37	43	80	171
Dakota Tipi	26	21	47	65	43	108	155
Dauphin River	50	44	94	10	10	20	114
Ebb and Flow	245	227	472	146	177	323	795
Fairford	384	380	764	145	146	291	1,055
Fisher River	431	402	833	297	298	595	1,428
Fort Alexander	982	880	1,862	547	592	1,139	3,001
Gamblers	5	2	7	16	16	32	39
Garden Hill	906	813	1,719	132	138	270	1,989
Hollow Water	214	220	434	71	76	147	581
Indian Birch	50	44	94	38	33	71	165
Jackhead	125	103	228	56	65	121	349
Keeseekoowenin	119	96	215	94	91	185	400
Lake Manitoba	225	200	425	148	167	315	740
Lake St. Martin	249	243	492	210	253	463	955
Little Black River	97	94	191	71	80	151	342
Little Grand Rapids	486	414	900	54	62	116	1,016
Little Saskatchewan	118	118	236	81	82	163	399
Long Plain	326	309	635	252	301	553	1,188
Oak Lake	138	136	274	48	55	103	377
Peguis	813	684	1,497	670	705	1,375	2,872
Pine Creek	224	208	432	200	193	393	825
Poplar River	295	279	574	24	36	60	634
Red Sucker Lake	213	198	411	10	7	17	428
Rolling River	133	127	260	81	86	167	427
Roseau River	307	284	591	209	230	439	1,030
Sandy Bay	779	738	1,517	356	320	676	2,193
Shoal River	236	174	410	88	99	187	597
Sioux Valley	429	400	829	159	183	342	1,171
St. Theresa Point	709	699	1,408	77	93	170	1,578
Swan Lake	106	113	219	188	235	423	642
Valley River	137	148	285	115	122	237	522
Wasagamack	344	343	687	18	22	40	727
Waterhen	171	154	325	88	85	173	498
Waywayseecappo	280	294	574	206	205	411	985
TOTAL	11,393	10,551	21,944	5,441	5,828	11,269	33,213

APPENDIX 1 (c)

MANITOBA REGISTERED INDIANS
POPULATION BY BAND
JUNE, 1984

NORTH ZONE	ON-RESERVE			OFF-RESERVE			COMBINED
	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	TOTAL
Barren Lands	156	153	309	41	38	79	388
Chemawawin	219	230	449	26	33	59	508
Churchill	151	128	279	66	81	147	426
Cross Lake	1,068	1,021	2,089	177	198	375	2,464
Fox Lake	122	109	231	59	86	145	376
God's Lake	498	480	978	122	142	264	1,242
God's River	134	127	261	7	7	14	275
Grand Rapids	156	139	295	57	60	117	412
Mathias Colomb	672	558	1,230	106	107	213	1,443
Moose Lake	160	175	335	25	24	49	384
Nelson House	1,037	985	2,022	106	125	231	2,253
Northlands	222	175	397	37	42	79	476
Norway House	1,237	1,213	2,450	170	202	372	2,822
Oxford House	591	530	1,121	48	44	92	1,213
Shamattawa	309	290	599	32	21	53	652
Split Lake	564	566	1,130	103	120	223	1,353
The Pas	718	647	1,365	84	106	190	1,555
War Lake	3	3	6	41	41	82	88
York Landing	157	157	314	78	65	143	457
TOTAL NORTH ZONE	8,174	7,686	15,860	1,385	1,542	2,927	18,787

MANITOBA REGION TOTALS

NORTH ZONE	8,174	7,686	15,860	1,385	1,542	2,927	18,787
SOUTH ZONE	11,393	10,551	21,944	5,441	5,828	11,269	33,213
TOTAL	19,567	18,237	37,804	6,826	7,370	14,196	52,000

SOURCE: MEDICAL SERVICES BRANCH
MANITOBA REGION

Manitoba Status Indian Population

Region	Indian Bands	December, 1981		December, 1982		June, 1983		December, 1983	
		Total Band Listing	Band Members With Winnipeg Postal Address	Total Band Listing	Band Members With Winnipeg Postal Address	Total Band Listing	Band Members With Winnipeg Postal Address	Total Band Listing	Band Members With Winnipeg Postal Address
Central	Dakota Tipi	130	16	133	14	140	18	147	26
	Dakota Plains	147	3	158	6	163	6	156	8
	Long Plains Sioux	977	206	1,017	194	1,066	218	1,020	212
	Sandy Bay	1,883	225	1,982	212	2,019	248	2,058	264
	Swan Lake	488	172	538	174	555	188	554	184
	Sub-Total	3,625	622(17.2%)	3,828	600(15.7%)	3,883	678(17.5%)	3,935	694(17.6%)
Eastman	Berens River	945	105	975	97	993	117	999	128
	Bloodvein	511	48	540	57	557	63	559	59
	Buffalo Point	20	0	22	0	22	0	22	0
	Fort Alexander	2,604	836	2,717	931	2,762	1,003	2,754	1,015
	Hollow Water	511	104	529	87	534	87	543	100
	Little Black River	318	123	321	109	321	105	321	102
	Little Grand Rapids	909	44	924	39	939	39	947	56
	Poplar River	571	64	590	81	598	77	611	78
	Roseau River	852	238	863	214	866	206	858	208
	Sub-Total	7,241	1,562(21.6%)	7,481	1,615(21.6%)	7,592	1,697(22.4%)	7,614	1,746(22.9%)
Interlake	Brokenhead	491	277	496	287	495	298	506	295
	Dauphin River	90	17	99	17	107	17	110	19
	Fairford	917	189	960	196	975	188	981	201
	Fisher River	1,190	324	1,222	328	1,225	323	1,243	319
	Jackhead	374	71	344	91	358	108	357	119
	Lake Manitoba	613	200	643	214	689	237	693	242
	Lake St. Martin	840	221	862	265	877	280	880	293
	Little Saskatchewan	352	103	340	104	341	105	341	110
	Peguis	2,219	620	2,355	658	2,373	649	2,376	627
	Sub-Total	7,086	2,022(28.5%)	7,321	2,160(29.5%)	7,440	2,205(29.6%)	7,487	2,225(29.7%)
Norman	Barren Lands	311	3	304	8	304	7	310	8
	Chemahawin	452	12	459	21	479	19	489	19
	Churchill	362	44	353	42	365	51	365	52
	Cross Lake	2,265	56	2,309	62	2,332	59	2,361	68
	Fox Lake	337	22	364	35	370	36	366	43
	Garden Hill	1,786	183	1,816	173	1,855	198	1,889	221
	God's Lake	1,159	110	1,177	135	1,200	138	1,205	166
	God's River	273	13	272	9	280	18	283	20
	Grand Rapids	352	41	357	33	360	34	368	31

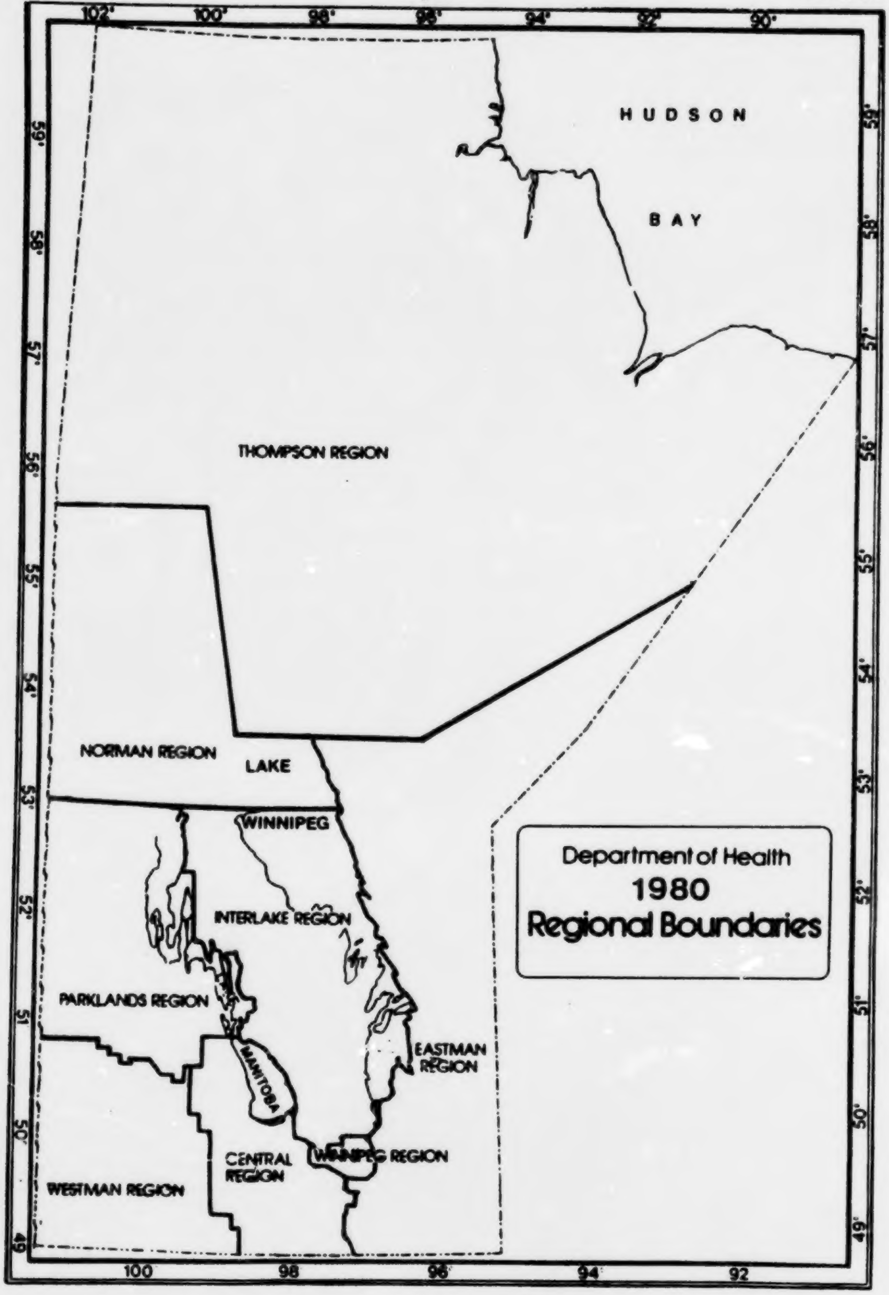
Manitoba Health Services Commission

Manitoba Status Indian Population

Region	Indian Bands	December, 1981		December, 1982		June, 1983		December, 1983	
		Total Band Listing	Band Members With Winnipeg Postal Address	Total Band Listing	Band Members With Winnipeg Postal Address	Total Band Listing	Band Members With Winnipeg Postal Address	Total Band Listing	Band Members With Winnipeg Postal Address
Norman (Cont'd)	Matthias Colomb	1,291	49	1,330	57	1,350	53	1,363	60
	Moose Lake	344	16	357	19	362	21	368	22
	Eskimo & O.O.P. Indians	355	172	399	212	429	225	453	249
	Nelson House	2,015	49	2,035	62	2,068	66	2,076	65
	Northlands	391	0	407	1	409	1	417	1
	Norway House	2,557	184	2,597	248	2,622	252	2,648	254
	Oxford House	1,181	21	1,209	18	1,234	18	1,238	19
	Red Sucker Lake	362	21	365	15	381	22	390	21
	Shamattawa	597	9	611	16	624	17	627	17
	Split Lake	1,274	18	1,231	22	1,248	38	1,276	44
	Ste. Theresa Point	1,503	83	1,578	96	1,591	81	1,614	74
	The Pas	1,284	44	1,351	67	1,362	79	1,391	85
	Wasagamack	669	38	707	38	706	48	719	51
	War Lake	0	0	88	1	87	1	89	2
	York Factory	426	38	416	25	419	18	423	14
	Sub-Total	21,546	1,226(5.7%)	22,092	1,415(6.4%)	22,428	1,500(6.7%)	22,728	1,606(7.1%)
Parkland	Crane River	203	32	215	42	217	37	231	40
	Ebb and Flow	673	91	701	125	719	128	728	131
	Indian Birch	0	0	143	3	149	5	149	10
	Pine Creek	653	182	687	203	706	208	714	208
	Shoal River	677	86	554	88	566	93	570	92
	Valley River	371	58	383	57	379	62	383	74
	Waterhen	421	64	426	63	435	76	453	78
	Sub-Total	2,998	513(17.1%)	3,109	581(18.7%)	3,171	609(19.2%)	3,228	633(19.6%)
Westman	Birdtail Sioux	241	20	240	13	243	12	246	13
	Gamlers	12	3	14	1	14	1	14	1
	Keeseekoowanin	310	39	317	31	323	38	335	31
	Oak Lake	304	23	313	30	321	31	327	35
	Rolling River	360	57	374	70	377	60	371	58
	Sioux Valley	1,016	58	1,024	57	1,029	53	1,044	71
	Waywayseecappo	830	122	802	94	792	86	802	90
	Sub-Total	3,073	322(10.5%)	3,084	296(9.6%)	3,099	281(9.1%)	3,139	299(9.5%)
Manitoba		45.569	6,267(13.8%)	46,915	*6,667(14.2%)	47,613	6,970(14.6%)	48,131	7,203(15.0%)

*Revised total.

Manitoba Health Services Commission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HUDSON
BAY
THOMPSON REGION
NORMAN REGION
LAKE
WINNIPEG
INTERLAKE REGION
PARKLANDS REGION
MANITOBA
EASTMAN REGION
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CENTRAL REGION
WESTMAN REGION
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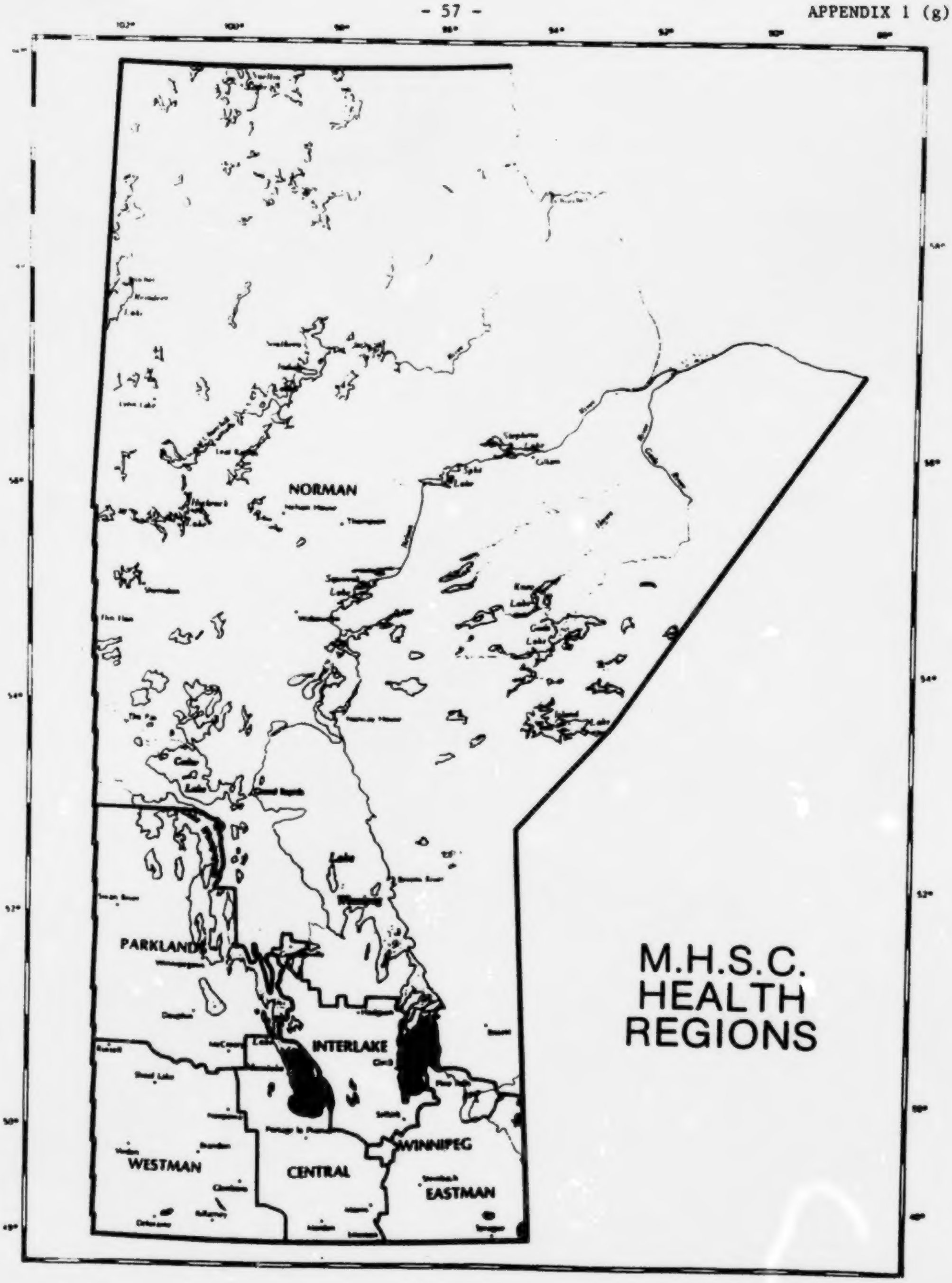
Department of Health
1980
Regional Boundaries



M.H.S.C.
HEALTH
REGIONS

NORMAN
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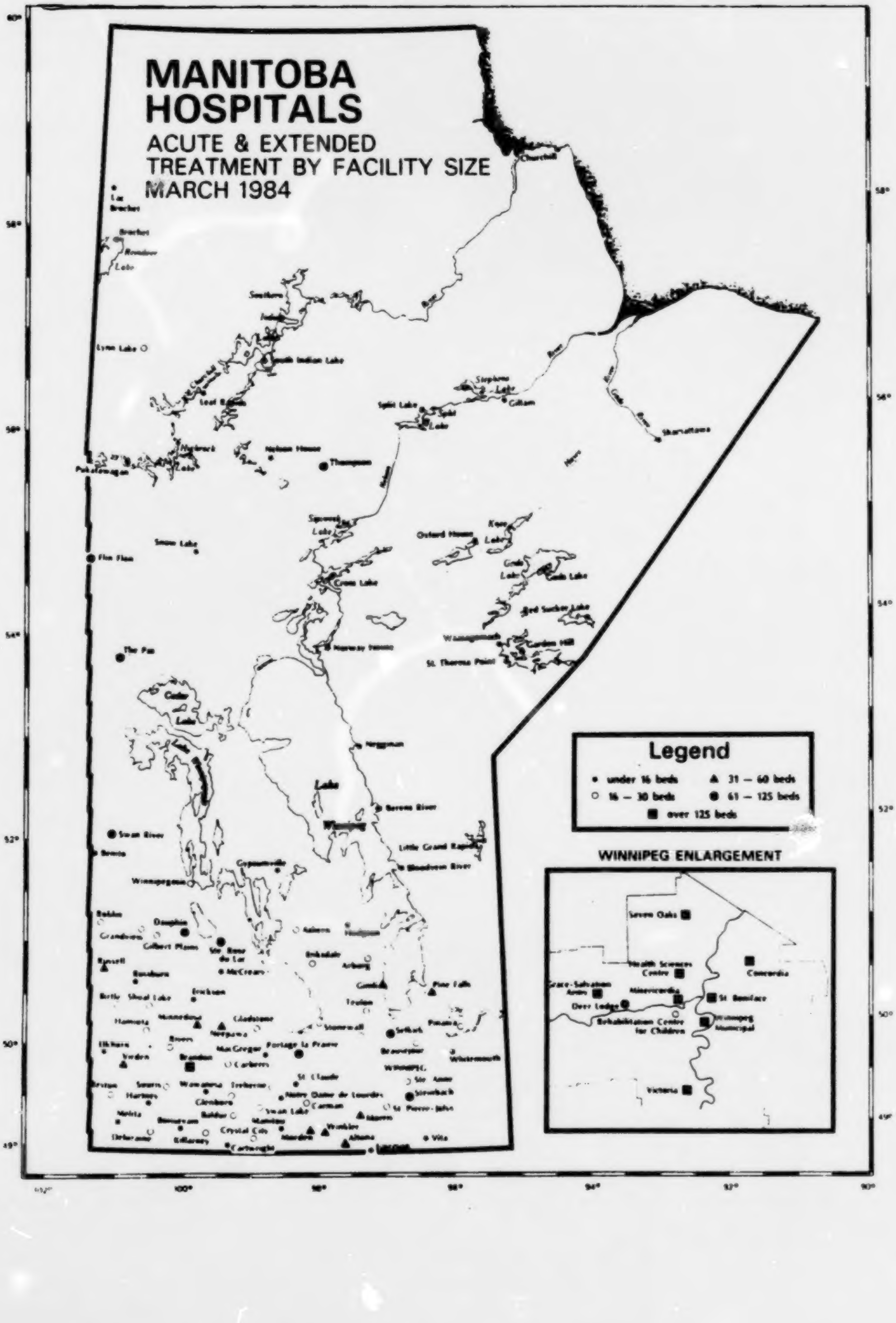
INTERLAKE
WESTMAN
CENTRAL
WINNIPEG
EASTMAN



MANITOBA HOSPITALS

ACUTE & EXTENDED TREATMENT BY FACILITY SIZE

MARCH 1984

Legend
• under 16 beds
○ 16 – 30 beds
▲ 31 – 60 beds
● 61 – 125 beds
■ over 125 beds
WINNIPEG ENLARGEMENT
Seven Oaks
Health Sciences Centre
Concordia
Grace-Salvation Army
Misericordia
St Boniface
Deer Lodge
Rehabilitation Centre for Children
Winnipeg Municipal
Victoria
Churchill
Lynn Lake
South Indian Lake
Leaf Rapids
Split Lake
Gillam
Shamattawa
Nelson House
Thompson
Pukatawagan
Snow Lake
Flin Flon
Oxford House
Cross Lake
God's Lake
Red Sucker Lake
Norway House
Wasagamack
Garden Hill
St. Theresa Point
The Pas
Berens River
Little Grand Rapids
Bloodvein River
Swan River
Benito
Winnipegosis
Roblin
Dauphin
Grandview
Gilbert Plains
Ste Rose du Lac
Russell
McCreary
Eriksdale
Arborg
Gimli
Pine Falls
Birtle
Shoal Lake
Erickson
Teulon
Hamiota
Minnedosa
Gladstone
Neepawa
Stonewall
Selkirk
Pinawa
Elkhorn
Rivers
Virden
Brandon
MacGregor
Portage la Prairie
Carberry
Beausejour
Whitemouth
WINNIPEG
St. Claude
Ste Anne
Souris
Wawanesa
Treherne
Notre Dame de Lourdes
Steinbach
Glenboro
Carman
Swan Lake
St Pierre-Jolys
Melita
Baldur
Morris
Boissevain
Manitou
Winkler
Crystal City
Morden
Altona
Deloraine
Killarney
Cartwright
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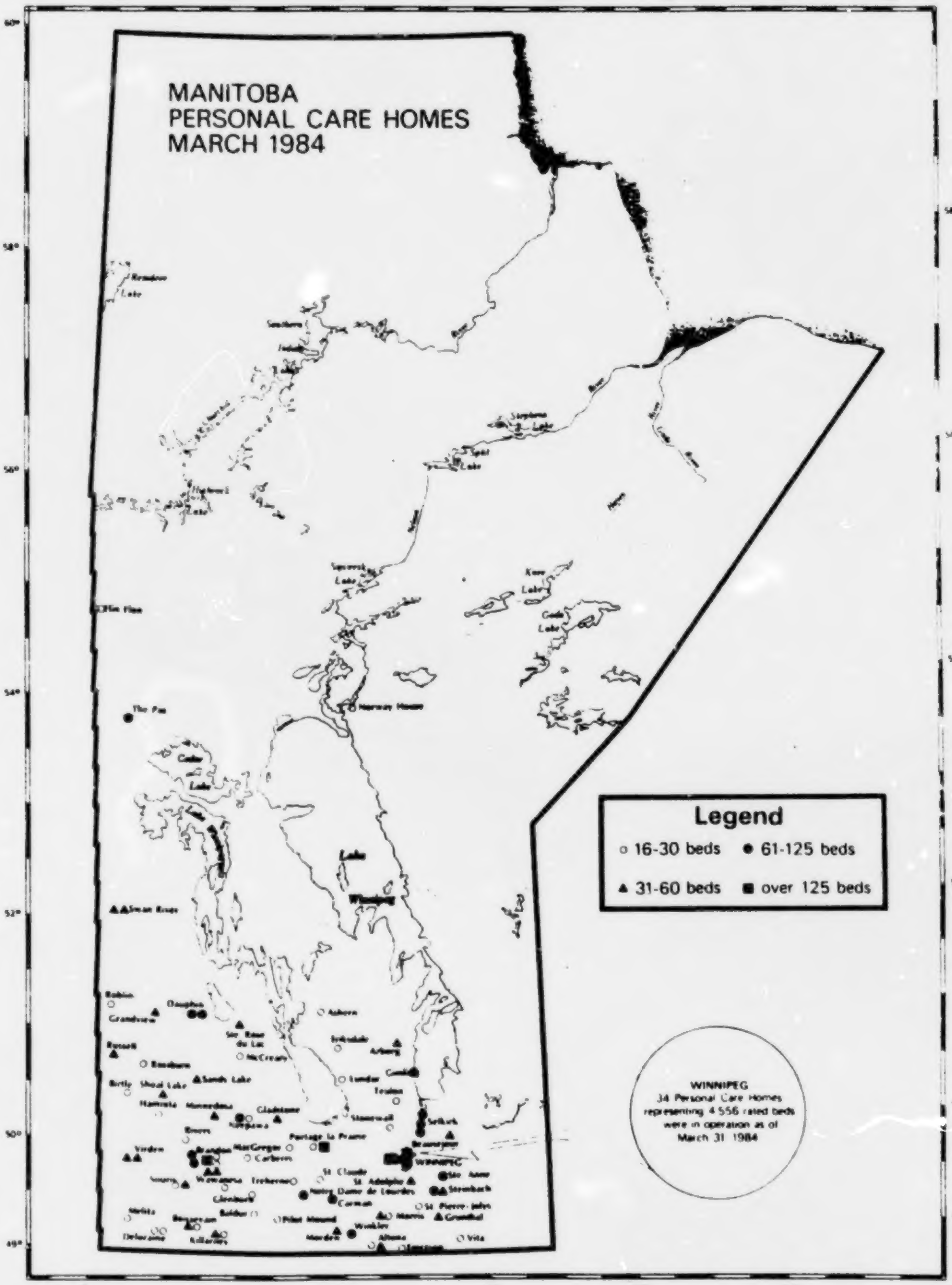
MANITOBA
PERSONAL CARE HOMES
MARCH 1984
Legend
○ 16-30 beds
● 61-125 beds
▲ 31-60 beds
■ over 125 beds
WINNIPEG
34 Personal Care Homes
representing 4 556 rated beds
were in operation as of
March 31 1984
Reindeer Lake
Southern Indian Lake
Split Lake
Flin Flon
The Pas
Norway House
Cedar Lake
Lake Winnipeg
Swan River
Roblin
Grandview
Dauphin
Ste. Rose du Lac
McCreary
Russell
Rossburn
Birtle
Shoal Lake
Sandy Lake
Hamiota
Minnedosa
Neepawa
Gladstone
Rivers
Virden
Brandon
MacGregor
Carberry
Portage la Prairie
Souris
Wawanesa
Treherne
Glenboro
Melita
Boissevain
Baldur
Deloraine
Killarney
Pilot Mound
Morden
Winkler
Altona
Emerson
Vita
Morris
Grunthal
St. Pierre-Jolys
Steinbach
Ste. Anne
Carman
Notre Dame de Lourdes
St. Adolphe
St. Claude
WINNIPEG
Beausejour
Selkirk
Stonewall
Teulon
Lundar
Gimli
Arborg
Eriksdale
Ashern
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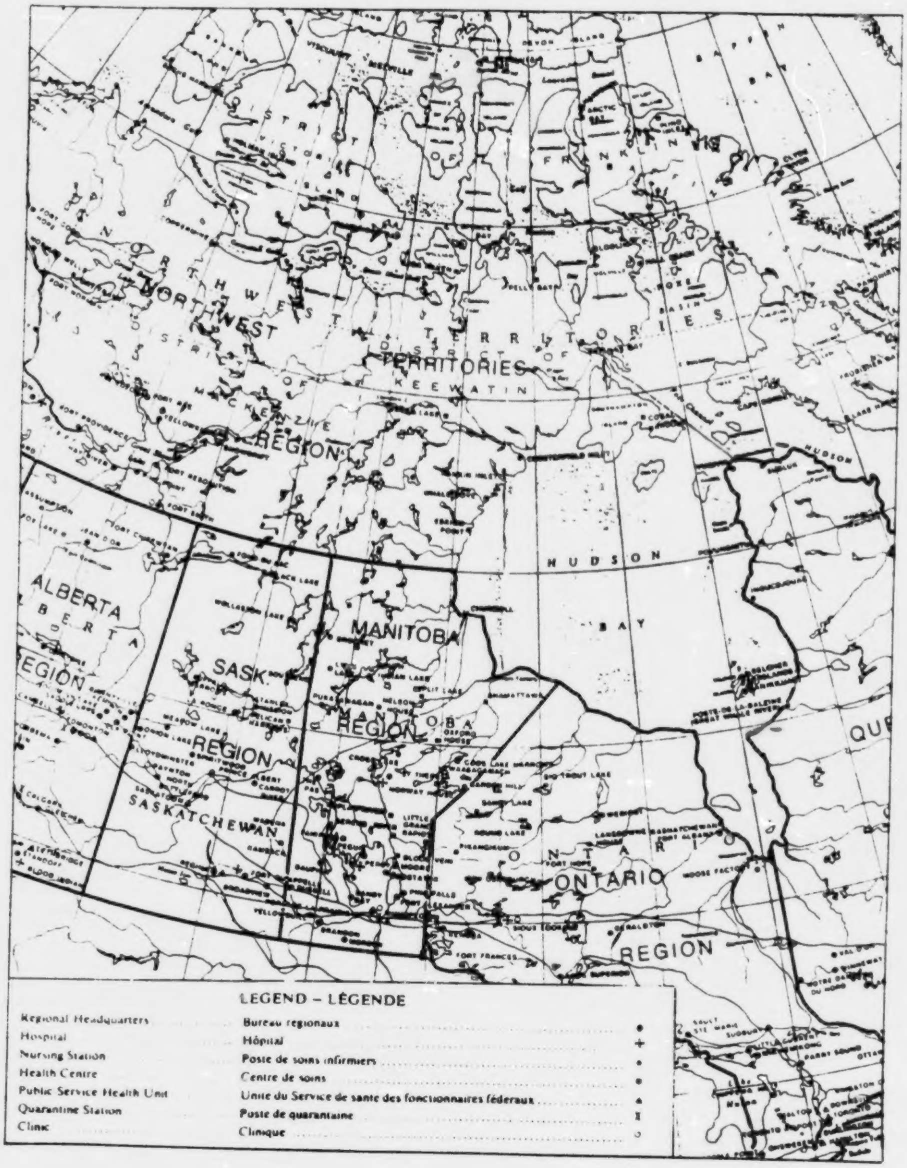
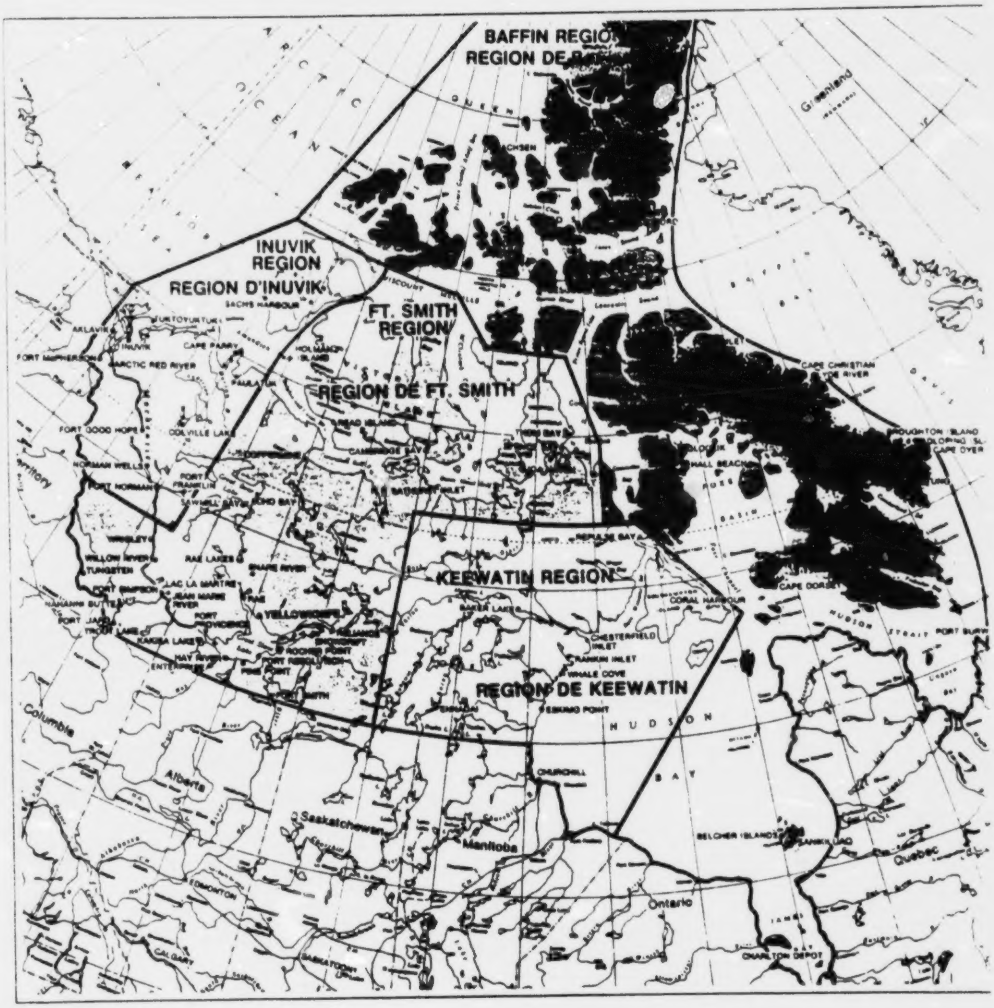
APPENDIX 1 (j)

Medical Services Branch, Health and Welfare Canada - Facilities


BAFFIN BAY
DISTRICT OF FRANKLIN
NORTHWEST TERRITORIES
DISTRICT OF MACKENZIE
NORTHWEST TERRITORIES REGION
DISTRICT OF KEEWATIN
HUDSON BAY
ALBERTA
ALBERTA REGION
SASK. REGION
SASKATCHEWAN
MANITOBA
MANITOBA REGION
ONTARIO
ONTARIO REGION
QU
LEGEND – LÉGENDE
Regional Headquarters — Bureau regionaux ●
Hospital — Hôpital ✚
Nursing Station — Poste de soins infirmiers •
Health Centre — Centre de soins ●
Public Service Health Unit — Unite du Service de sante des fonctionnaires féderaux ▲
Quarantine Station — Poste de quarantaine I
Clinic — Clinique ○

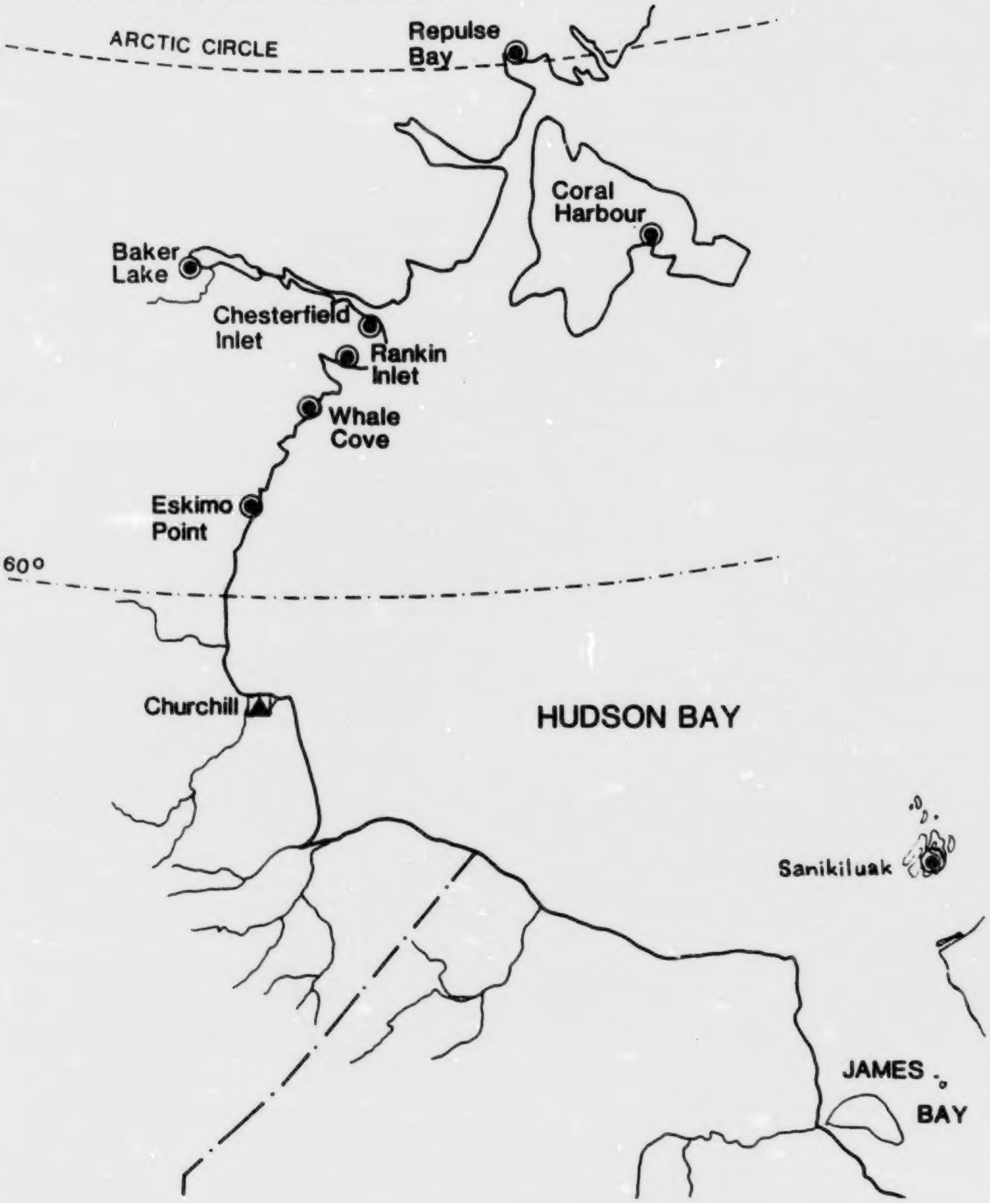
APPENDIX 1 (k)


BAFFIN REGION
REGION DE BAFFIN
ARCTIC OCEAN
Greenland
INUVIK REGION
REGION D'INUVIK
SACHS HARBOUR
TUKTOYAKTUK
AKLAVIK
INUVIK
FORT McPHERSON
ARCTIC RED RIVER
CAPE PARRY
PAULATUK
HOLMAN ISLAND
FT. SMITH REGION
REGION DE FT. SMITH
FORT GOOD HOPE
COLVILLE LAKE
NORMAN WELLS
FORT NORMAN
FORT FRANKLIN
CAMBRIDGE BAY
COPPERMINE
THOM BAY
BATHURST INLET
IGLOOLIK
HALL BEACH
CAPE CHRISTIAN
CLYDE RIVER
BROUGHTON ISLAND
CAPE DYER
WRIGLEY
WILLOW RIVER
TUNGSTEN
RAE LAKES
SNARE RIVER
FORT SIMPSON
LAC LA MARTRE
JEAN MARIE RIVER
RAE
YELLOWKNIFE
FORT PROVIDENCE
NAHANNI BUTTE
FORT LIARD
KAKISA LAKE
HAY RIVER
ENTERPRISE
PINE POINT
FORT RESOLUTION
FORT SMITH
REPULSE BAY
KEEWATIN REGION
REGION DE KEEWATIN
BAKER LAKE
CHESTERFIELD INLET
RANKIN INLET
WHALE COVE
ESKIMO POINT
CORAL HARBOUR
CAPE DORSET
HUDSON STRAIT
HUDSON BAY
CHURCHILL
BELCHER ISLANDS
Columbia
Alberta
Saskatchewan
Manitoba
Ontario
Quebec
EDMONTON
CALGARY
SASKATOON
JAMES BAY
CHARLTON DEPOT
Territory

The Northwest Territories

Inuit Communities in the Keewatin District, N.W.T.
Served by the Churchill Health Centre

APPENDIX I (1)


ARCTIC CIRCLE
Repulse Bay
Coral Harbour
Baker Lake
Chesterfield Inlet
Rankin Inlet
Whale Cove
Eskimo Point
60°
Churchill
HUDSON BAY
Sanikiluak
JAMES BAY

APPENDIX 2

Subcommittee on Indian Health Care

Schedule of Meetings and Topics

SESSION 1	October 15	Overview of Committee Morbidity Mortality Utilization
SESSION 2	October 25	Structure and Jurisdictional Interaction of Health Services
SESSION 3	November 1	Manpower and Education
SESSION 4	November 8	Urban
SESSION 5	November 15	Research and Evaluation
SESSION 6	November 22	Regionalization Evacuation
SESSION 7	November 29	Socio-political Contexts of Health
SESSION 8	December 6	Northwest Territories
SESSION 9	December 13	Indian Self Control
SESSION 10	December 20	Wrap-up
SESSION 11	April 12	Wrap-up

Community Infokit

May, 1984

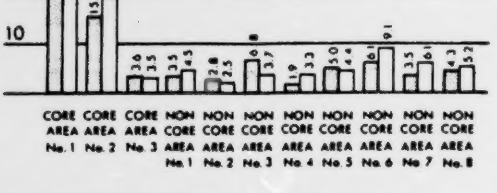
WINNIPEG'S NATIVE POPULATION

Natives compared to non-natives--what is the story in Winnipeg? How many Natives live in Winnipeg? What problems do they face socially and economically? Who are Native people? Answering the last question first, Native people are defined for census purposes as being status and non-status Indians, Metis and Amerindians.

POPULATION

There are 16,000 Native people living here. They make up 2.9% of the total population of Winnipeg.* In 1971 there were only 6,420 Native people (1.2% of the population). From 1971 through 1981 there was an increasing concentration of Natives in the Core area, growing from 3.1% of the total Core Area population to 7.2%. Over those ten years, the Native population has moved away from the area around the C.P.R. tracks, and down into the West End and Wolseley areas. However, proportionately more Natives also lived outside the Core in 1981 (47%) than in 1971 (38%). There has been an increase in the Fort Rouge, West End, North West and East Kildonan, Transcona, St.Vital and South Fort Garry areas in particular.

CHANGES IN THE GEOGRAPHICAL DISTRIBUTION OF THE NATIVE POPULATION OF WINNIPEG 1971-81

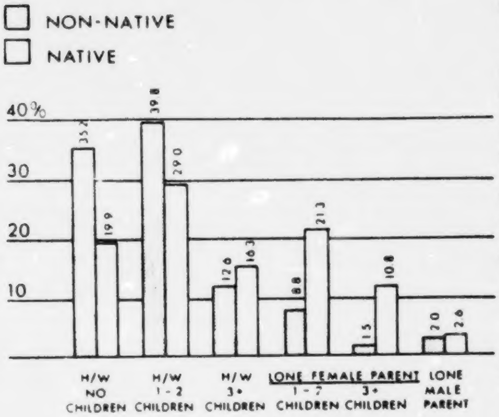


LEGEND

Core Area #1 - Notre Dame - Church, Red River - McPhillips
Core Area #2 - Assiniboine River - Notre Dame, Red River - Ingersoll
Core Area #3 - River - Osborne and North St. Boniface
Non-Core #1 - Fort Rouge & Riverview
Non-Core #2 - Fort Garry, River Heights, Tuxedo, Charleswood
Non-Core #3 - East & West St. James
Non-Core #4 - West End-Ingersoll-Polo Park, Assiniboine - Notre Dame
Non-Core #5 - Weston & Burrows - Keewatin
Non-Core #6 - North Winnipeg & West Kildonan (Church-Perimeter, Red River - McPhillips)
Non-Core #7 - East Kildonan
Non-Core #8 - Elmwood & Transcona
Non-Core #9 - Norwood - 1971= 1.5% 1981=1.4%
Non-Core #10 - St.Vital & Windsor Park - 1971= 2.4% 1981= 4.0%
Non-Core #11 - South Fort Garry - 1971= 0.2% 1981= 2.6'

* ' These are the municipal boundaries (Census Division II which exclude C.T.'s 150,570,580,590, and 600).

COMPOSITION OF NATIVE AND NON-NATIVE CENSUS FAMILIES



What is the Native family structure? How does it compare with non-natives?

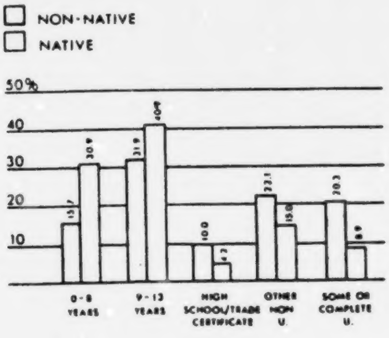
Of the 5,900 Native households in 1981, 81% were family households (non-native, 58%). 13% were single people living alone (25% non-native) and 6% were two or more non-family people living together.

Fewer Native families are childless (20% are childless vs 35% of non-native families). And there is a slightly larger proportion of Native families with three or more children (17% vs. 14%). More striking is the high number of single mothers among native families (32% vs. 10%). Furthermore, 34% of these single parent families have three or more children, compared to only 14% of non-native single mother families.

EDUCATION

In 1981, there were 9,800 Native people aged 15 and older. 31% of them had Grade 8 or less. Another 41% had less than a complete high school education. 29% of Natives have at least a high school diploma, compared to 52% of Winnipeg's non-native population. 33% of Native youth attend school full time, compared with 41% of non-native youth.

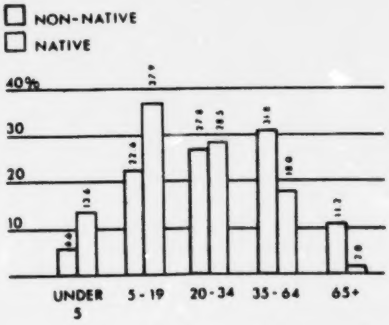
EDUCATIONAL ATTAINMENT OF NATIVE AND NON-NATIVE PERSONS 15+ YEARS - 1981



AGE STRUCTURE

Apart from the larger number of single parent families, a second important factor for the Native population is its comparative youth. 52% of the Native population is under 20, compared with only 29% of the non-natives. The flip side is that only 2% of the Native population is 65 or older, compared with 11% for the non-natives. There is very little difference in age structure between status and non-status Natives.

AGE DISTRIBUTION OF THE NATIVE AND NON-NATIVE POPULATION-1981



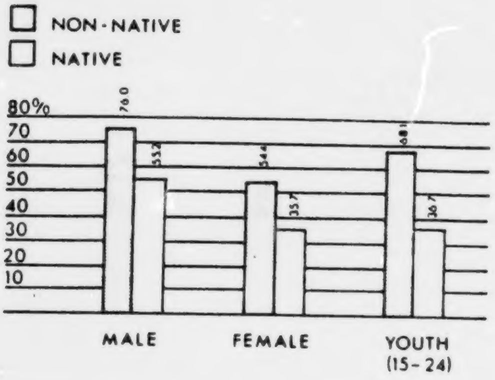
EMPLOYMENT

What problems do Native adults have with unemployment? Are their problems worse than non-natives? The answer, unfortunately, is that Natives have a very bad unemployment problem in Winnipeg.

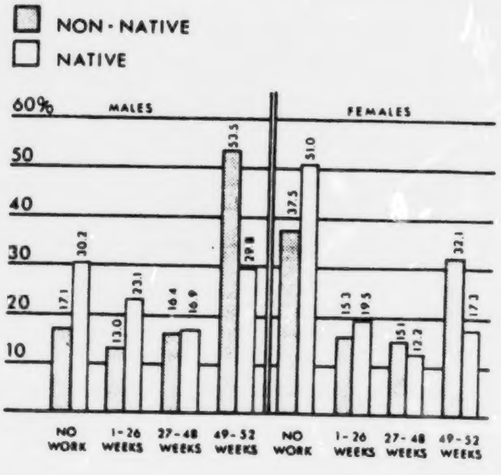
Of the 4,155 Native men in 1980 who were 15 or older, 30% did not work at all (compared with 17% of non-natives). Those who did work were more likely to have worked less than 48 weeks. The work they did get was more likely to be full time rather than part time. In fact, 77% of the Native men who worked between 1 and 26 weeks worked full time, compared with 66% for non-native men who worked from 1 to 26 weeks.

The trend is similar for the 5,650 Native women, with proportionately more of them not working at all, or working for only part of the year. 64% of the Native women who worked from 1 to 26 weeks had full time jobs, compared with 48% of non-native women. Worst off are Native youth, whose employment rate is only half that of non-native youth (37% vs. 68%). The findings suggest that the work Natives are able to find in Winnipeg is likely to be either temporary or seasonal, and not permanent.

THE PROPORTION OF THE MALE, FEMALE AND YOUTH POPULATIONS EMPLOYED - JUNE 1981



NUMBER OF WEEKS WORKED IN 1980



INCOME

When Natives can find work, how much do they earn? This table illustrates the dramatic differences between the incomes of Natives and non-natives. Almost 45% of Winnipeg's Native families had incomes under $10,000, compared to only 11.5% for non-natives. Conversely, only 17% of all Native families had incomes above $25,000, compared with 49% of non-native families. Such huge income differences exist partly because the average income of Native single parent families, 32% of all Native families, is only $6,941.

HOUSING

We've seen the income problems Natives have in Winnipeg. And we've seen where in the City they live. But what do Natives live in? 79% of the 5,905 Native households rent their housing, compared to only 41% of non-native households. Most Native families, because of their low incomes, simply can not afford to buy their own homes.

Compared with non-native households, Natives are more likely to live in dwellings requiring major repairs (11% vs. 5%) and are more likely to experience overcrowding (8% vs. 2%). However, the differences are not dramatic, and few households are affected.

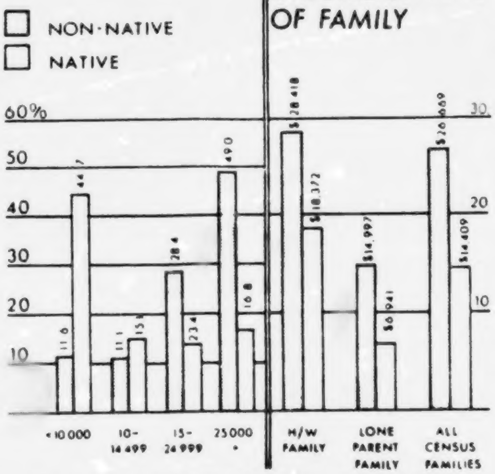
Rundown or overcrowded homes, therefore, are not a major problem. What Native renter households are far more likely to experience are budget problems. Over 63% of Native renters must spend more than 25% of their income on shelter, compared to only 34% of non-native households. This fact is hardly surprising, given the low incomes of most Native families. Apart from having to spend a larger proportion of income on shelter, because so many Natives must rent they also must face problems with transience, and difficulty in putting down roots in the City.

CONCLUSION

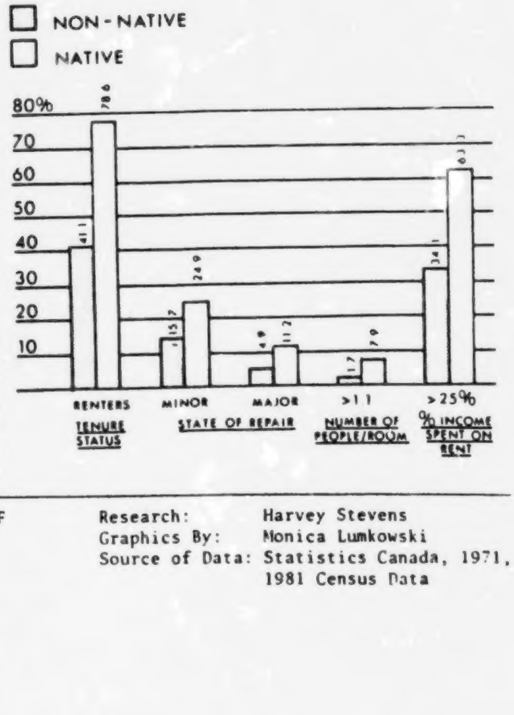
Native families tend to be larger and poorer than non-native families. Work is harder to get than for non-natives, and when they do get work it is likely to be only temporary, and pay less. Because of their low incomes, Natives must pay a higher proportion of their budget for housing, which of course makes inroads on what they can afford for food, clothing and education. And the large number of single parent families indicates it will be very difficult for Natives to raise their overall incomes and living conditions without substantial help from the three levels of government assisting Natives.

1980 CENSUS FAMILY INCOME

AVERAGE 1980 CENSUS FAMILY INCOME BY TYPE OF FAMILY



HOUSING CONDITIONS OF NATIVE AND NON-NATIVE HOUSEHOLDS



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Winnipeg, R3A OA9

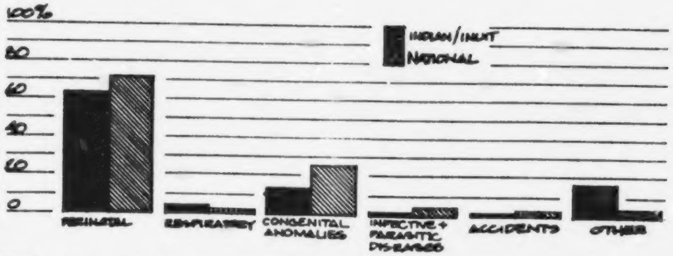
Research: Harvey Stevens
Graphics By: Monica Lumkowski
Source of Data: Statistics Canada, 1971, 1981 Census Data

SOCIAL CONDITIONS
health

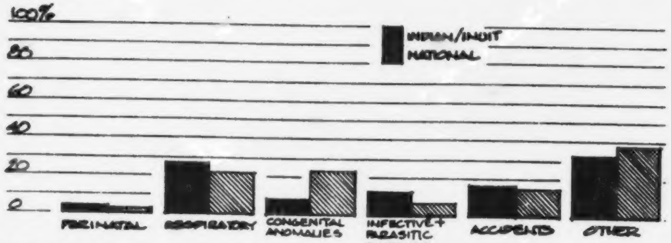
APPENDIX 4 (a)

CAUSES OF INFANT MORTALITY

NEONATAL (FIRST 4 WEEKS)



POST-NEONATAL (4 WEEKS TO 1 YEAR)



sources

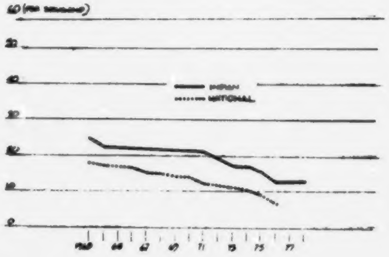
(1) *Annual Report, 1977 Medical Services Branch,* Health and Welfare Canada

(2) Statistics Canada, 1974

The leading causes of perinatal (foetal deaths of 28 or more weeks' gestation plus infant deaths under 7 days of age) and neonatal mortality (deaths under 28 days of age) for both Indian and national populations are complications at birth and congenital anomalies, accounting for more than 75 per cent of perinatal and neonatal deaths.

A larger proportion of post-neonatal mortality (deaths from 1 month to 1 year) in the Indian population is attributed to respiratory ailments and infectious or parasitic diseases, reflecting poor housing, lack of sewage disposal and potable water, as well as poorer access to medical facilities.

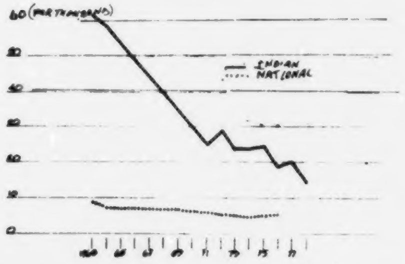
NEONATAL MORTALITY
Deaths under 28 Days



sources
(1) Regional Reports 1978, Medical Services Branch, Health and Welfare Canada
(2) *Vital Statistics*, 1976, Statistics Canada

Lowered perinatal and neonatal mortality has kept pace with national improvements, although the Indian rate is currently approximately 60 per cent higher than the national.

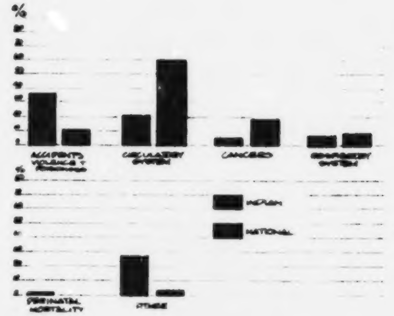
POST-NEONATAL MORTALITY
~~Deaths~~ Between 4 Weeks and I YEAR



sources:
(1) Regional Reports 1978, Medical Services Branch Health and Welfare Canada
(2) *Vital Statistics*, 1976, Statistics Canada

Post-neonatal mortality nonetheless has shown great improvements for Indians, plummeting from 6 times the national rate in 1963 to approximately twice the national rate in 1977.

MAJOR CAUSES OF DEATH
1977



source
Annual Report 1977 Medical Services Branch, Health and Welfare Canada

Accidents, violence and poisonings account for over one-third of all deaths among Indians compared with 9 per cent in Canada as a whole.

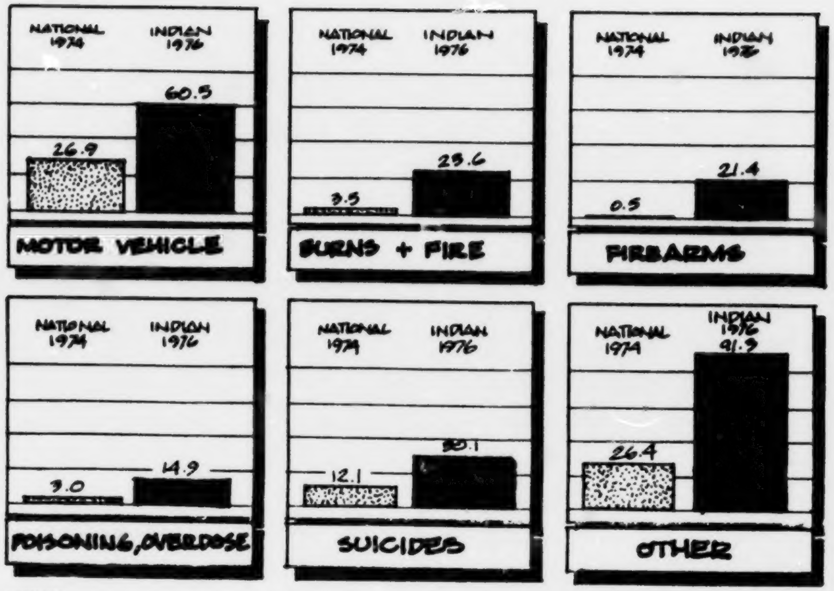
Respiratory and digestive system diseases have decreased significantly as causes of death and, in the Indian population, are now comparable to the national rates.

Indian rates of death from cancer and circulatory diseases are less than half the national rate.

SOCIAL CONDITIONS
health

APPENDIX 4 (c)

VIOLENT DEATHS
Per 100,000 Population



sources:

(1) *Medical Services Branch: Annual Report, 1978,* Health and Welfare Canada

(2) *Vital Statistics,* Statistics Canada, 1974

The overall rate of violent deaths for Indians is more than 3 times the national average. These deaths may be comparable in non-Indian rural and remote populations where there is:

- greater use of firearms for hunting
- substandard housing and heating systems
- inadequate fire-fighting equipment
- poor access to medical assistance.

Violent deaths among Indians are higher than in the national population at all age levels. With the exception of those over 65, violent deaths among Indians range from a low of 3 times the national rate in the 5-14 age group to a high of between 4 and 5 times the national rate in the 15-44 age group.

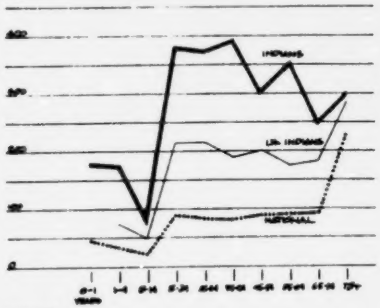
For Indians 1-14 years, burns, drowning and motor vehicles accounted for 69 per cent of accidental deaths.

For Indians 15 years and older, the leading causes were motor vehicle accidents (29 per cent), drowning (10 per cent) and firearms (9 per cent).

APPENDIX 4 (d)

VIOLENT DEATHS (AGE SPECIFIC)

Accidents, Poisoning and Violence per 100,000 Population at Each Age Level



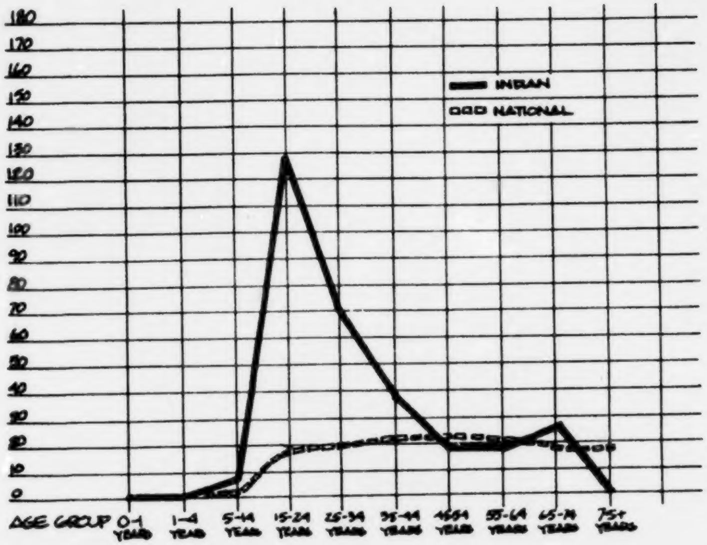
sources:

(1) *Annual Report, 1978: Medical Services Branch,* Health and Welfare Canada
(2) DIAND
(3) Statistics Canada
(4) *Trajectory of Indian Health Care,* U.S. Department of Health, Education and Welfare

The number of Indian deaths due to suicide per 100,000 population is almost 3 times the national rate. Suicides account for 35 per cent of accidental deaths in the 15-24 age group and 21 per cent in the 25-34 age group.

SUICIDES

Per 100,000 Population at Each Age Level
1977



sources:

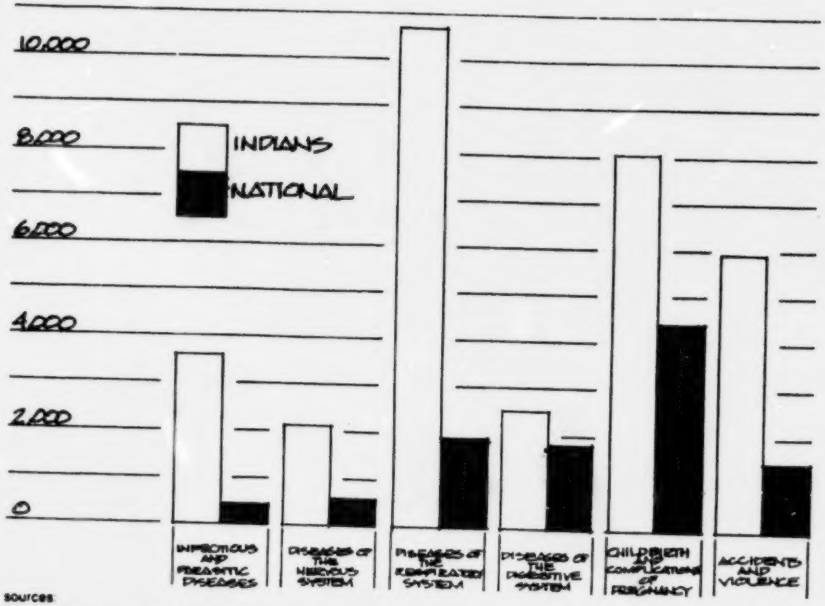
(1) *Annual Report, 1978. Medical Services Branch,* Health and Welfare Canada
(2) 1977, DIAND (Indian Population)
(3) 1976, Statistics Canada (National Population)

SOCIAL CONDITIONS
health

APPENDIX 4 (e)

ILLNESS

Hospital Admissions per 100,000 Population, 1976



sources:

(1) *Hospital Morbidity*. Catalogue 82-206. Statistics Canada, 1975

(2) Unpublished data, Health Division, Statistics Canada[2]

Indians use hospitals about 2 to 2.5 times more than the national population, but on the average stay less time (7.3 days compared to 9.1).

The high incidence of respiratory ailments, infectious and parasitic diseases and digestive disease may reflect poor or unsanitary housing and living conditions.

The high incidence of childbirth complications may indicate malnutrition and lack of prenatal care.

The high accident rate may reflect the hazards of a rural and remote life style, which includes high use of firearms for hunting, higher fire risk and poorer access to medical facilities.

APPENDIX 5 (a)

New Management Initiatives

Initial Results from the Ministerial Task Force on Program Review

The Honourable Erik Nielsen
Deputy Prime Minister
and Chairman of the
Ministerial Task Force on
Program Review
May 1985

Mixed Study Team on Native Programs

Background

Some 106 programs, estimated to cost in the order of $2.2 billion in 1984/85 are directed in whole or in part toward native peoples by the Government of Canada. These involve 7,850 person-years in the direct employ of the federal government, largely in INAC. In addition, substantial funds are identifiable in Secretary of State, NHW, CEIC, CMHC, DRIE, DFO, Transport Canada, Solicitor General, PSC and Justice for this client group.

The 1981 Census enumerated an aboriginal population of approximately 552,000 persons, divided into four categories:

- Status Indians – 350,000 (577 Bands);
- Inuit – 27,000;
- Non-status Indians – 75,000; and
- Métis – 100,000.

This population is significantly different than the general Canadian population because of its age structure and socio-economic and cultural characteristics. Nationally, 52 per cent of aboriginals are under 20 years of age compared to 32 per cent for the rest of the population. While the growth rate has declined dramatically in the past ten years it still remains twice the national average. This population has much lower than average educational attainment and, subsequently, high unemployment with those employed tending to be concentrated in low-skill occupations. Only 22 per cent of the adult aboriginal population has training beyond high school compared to 40 per cent of the rest of the Canadian population. The age-structure, high growth rates and low educational attainment all point to a significant and ongoing policy concern.

It is noted that many of the figures used are only "best estimates": simply because, with the exception of the members of Registered Indians (which could change if some Non-status Indians are reinstated), no one really knows the total population size (estimates for Métis range from 100,000 to over 1 million). As well, given the comprehensive nature of INAC's mandate, there are likely duplications and gaps in programs and perhaps even double counting of some expenditure estimates. Provincial expenditures, even where the federal government may have jurisdiction, may in fact be substantially higher than provincial governments may realize.

Finally, one may ask whether some programs are in place for Native people because they are Native or because they are poor and disadvantaged.

Annex

Socio-Economic Circumstances of Canada's Aboriginal Peoples

Introduction

This annex presents some basic data on the demographics and socio-economic circumstances of Canada's aboriginal population. There are limitations inherent in any discussion of the characteristics of aboriginal peoples – while there is little dispute about the numbers and circumstances of status Indians and Inuit, there is a lack of specific information on the Métis and Non-status Indian (MNSI) population. This results partly from a question of ancestry and self-identification; there is no legal or broadly accepted definition of who constitutes this group and, therefore, the estimated population varies depending on the source.

Indians

- A **Status Indian** is a person registered or entitled to be registered as an Indian according to the *Indian Act*. In 1984 there are estimated to be 350,000 Status Indians made up of 577 bands of varying sizes. Approximately 50 per cent of the Status Indians in Canada are treaty Indians who belong to a body or band of Indians who were signatories to a treaty with the Crown.
- **Non-status Indians** generally include Indian people or those descended from them who, for one reason or another, have lost their right to be registered as Indians as defined by the *Indian Act*. This group (about 75,000 self-identified for the 1981 Census) includes Indian women who have lost their status through marriage to non-Indian men.

Inuit

- The Inuit (approximately 27,000 persons) are the aboriginal inhabitants of northern Canada, who generally reside in the Northwest Territories, although some live in northern Quebec (5,000) and Labrador (2,000). The federal government's power under section 91 (24) of the *Constitution Act, 1867* to make laws in respect to "Indians, and Lands reserved for the Indians" was interpreted to extend to Inuit by the Supreme Court of Canada in 1939. However, Inuit are not covered by the *Indian Act*.

Métis

- There are two broad definitions of Métis. Some maintain that the term refers to those of mixed European and aboriginal ancestry who descended from the historic Métis community of western Canada. Others say the term refers to anyone of mixed European and aboriginal ancestry who identifies as Métis, as distinct from Indian or Inuit. The 1981 Census counted approximately 100,000 Métis, based on self-identification.

General

Much of the information which follows has been extracted from the 1981 Census of Canada. The population estimates for aboriginal peoples in the Census are based on a sample of the population using the principle of self-identification and consequently it is not possible to state definitely that the Census "accurately" determined the number of aboriginal peoples or their circumstances. While there remains a significant debate on the numbers partly because of the definitional problems described above, there appears to be a consensus that the Census accurately portrays the socio-economic circumstances of all aboriginal groups.

Geographic Distribution

- Eighty per cent of the aboriginal population lives in provinces west of Quebec.
- Eighty-four per cent of the Métis and Non-status Indian population lives in the Prairie provinces.
- Sixty per cent of Status Indians live on reserves and an additional 10 per cent on Crown land. These are generally situated in either rural or remote locations. The majority of other Status Indians live in the major metropolitan centres in western Canada. For example, 33 per cent of aboriginal peoples residing in Alberta live in Edmonton and Calgary.
- MNSI tend to be more urban with 60-70 per cent living in urban areas. .
- The proportion of off-reserve Indians has been rising steadily in the past two decades from 15 per cent in 1966 to 30 per cent in 1983.

Population

- The aboriginal population is significantly younger than the national population. Fifty-two per cent of aboriginals are under 20 years of age compared with 32 per cent for Canada. Only 3.5 per cent of this population is 65 and over compared with ten per cent for the nation.
- Age structure has important labour force implications. In the Prairies, for example, one in six children under the age of 15 years is of aboriginal ancestry. The working age aboriginal population is expected to grow at an

annual rate of 2.9 per cent – nearly three times the corresponding rate for the remainder of the population. It is estimated that by 1991, one in four people entering the labour force in western Canada will be of aboriginal ancestry and for Manitoba and Saskatchewan, the ratio is nearly one in two.

- Fertility rates for Status Indians have been falling in concert with national rates but still remain twice the Canada average.

Education

- Seventy per cent of the aboriginal population have less than high school graduation compared to 45 per cent for the national average. Thirty-eight per cent have less than grade eight compared to 20 per cent for the country as a whole.
- Approximately 20 per cent of Indian students complete high school compared to a national rate of 75 per cent.
- Participation rates for Indians 14-18 years in secondary schools is around 30 per cent.
- Accessibility to secondary schools is constrained for much of the aboriginal population. Many children from remote or rural communities must leave home to attend high school.

Labour Force

- The working age segment comprises 57 per cent of the total aboriginal population compared with 68 per cent for the nation.
- Participation in the labour force differs dramatically between aboriginal peoples and the rest of the population.

Reported Labour Force Participation Rates
(Per Cent of Working Age Population)

	Male		Female	
	Native	Other	Native	Other
Man.	55.2	78.8	31.8	53.4
Sask.	56.3	79.2	31.5	49.3
Alta.	65.2	85.2	39.6	58.7
B.C.	66.9	78.6	43.2	53.0
Yukon	65.1	87.4	48.5	71.1
N.W.T.	54.7	91.7	39.7	72.9

Source. 1981 Census of Canada.

- Unemployment rates for aboriginal peoples are significantly higher than for the rest of the population. In western and northern Canada, the rates are at least twice as high, varying between 25 and 55 per cent.
- Seasonal employment is common. Of those who were employed in 1980, just over half of the male aboriginal work force worked 40 to 52 weeks.
- Aboriginal males are concentrated in construction-related occupations and are under-represented in managerial, technical and professional fields. Aboriginal women are more likely to work in service occupations and less likely to have clerical jobs than other women.

Income

- Average individual aboriginal incomes were approximately two-thirds of the national average in 1980.
- The proportion of aboriginal income in the form of government transfer payments is double that of other Canadians, constituting the second largest source of income for aboriginal peoples.
- Aboriginal peoples in rural areas are twice as dependent on transfer payments as aboriginal peoples living in urban areas.

Family Status

- Aboriginal families and households are larger than those of other Canadians and are more apt to include extended family members.
- Household income is lower than for other Canadians and does not necessarily rise as the number of family members increases, as it does for the rest of the population.
- The rate of single parent households is twice that of the general population.
- The number of status Indian children in care (i.e., under the protection of a child welfare authority) is five times the national rate.

Housing

- Nearly 50 per cent of Indian families live in crowded conditions.
- Less than 50 per cent of Indian houses are fully serviced with sewer and water compared to a national rate of 90 per cent.

Crime

- In 1979, Status Indians comprised 70 per cent of all admissions to federal penitentiaries in the Prairie provinces.
- About 70 per cent of Status Indians can expect to be incarcerated in a provincial correctional centre by age 25 compared to eight per cent for other Canadians.
- Most crimes committed by Indians involve drunken driving, theft and robbery.
- The juvenile delinquency rates for Indians is three times the national rate.

Health

- Indians use hospitals 2-2.5 times more than the national population but on average stay slightly less time.
- Accidents, violence and poisonings account for over one-third of all Indian deaths, more than three times the national rate. Suicides are still very high, six times the national rate, and particularly in the 15-24 age group.
- High infant mortality rates persist, approximately 60 per cent higher than the national rate, attributed to respiratory ailments and infectious and parasitic diseases reflecting poor housing, and lack of sewage disposal and potable water.

NEW INDIAN HEALTH POLICY

December 13, 1979

The following statement represents current Federal Government practice and policy in the field of Indian Health. It differs from the Indian Health Policy Statement of November 1974 in that it emphasizes issues which the Federal Government considers to be of greatest significance in the immediate future. Studies relating to Indian Health Policy and Practice are being undertaken by the National Indian Brotherhood and some Provincial Indian Associations, studies which National Health and Welfare supports. The Federal Government is committed to joining with Indian representatives in a fundamental review of issues involved in Indian Health when Indian representatives have developed their position, and the policy emerging from that review could supercede this policy. As an indication of good faith, the Federal Government has withdrawn the guidelines for the provision of uninsured health benefits to Indian and Inuit people of September 1978, which will be replaced by professional medical or dental judgement, or by other fair and comparable Canadian standards.

The Federal Indian Health Policy is based on the special relationship of the Indian people to the Federal Government, a relationship which both the Indian people and the Government are committed to preserving. It recognizes the circumstances under which many Indian communities exist, which have placed Indian people at a grave disadvantage compared to most other Canadians in terms of health, as in other ways.

Policy for Federal Programs for Indian people, (of which the Health Policy is an aspect), flows from constitutional and statutory provisions, treaties and customary practice. It also flows from the commitment of Indian people to preserve and enhance their culture and traditions. It recognizes the intolerable conditions of poverty and community decline which affect many Indians, and seeks a framework in which Indian communities can remedy these conditions. The Federal Government recognizes its legal and traditional responsibilities to Indians, and seeks to promote the ability of Indian communities to pursue their aspirations within the framework of Canadian Institutions.

The Federal Government's Indian Health Policy reflects these features in its approach to programs for Indian people. The over-riding fact from which the policy stems is the intolerably low level of health of many people, who exist under conditions rooted in poverty and community decline. The Federal Government realizes that only Indian communities themselves can change these root causes and to do so will require the wholehearted support of the larger Canadian community.

Hence, the goal of the Federal Indian Health Policy is to achieve an increasing level of health in Indian communities, generated and maintained by the Indian communities themselves.

PILLAR I - COMMUNITY DEVELOPMENT

This increasing level of health in Indian communities must be built on three pillars. The first, and most significant, is community development, both socio-economic development and cultural and spiritual development, to remove the conditions of poverty and apathy which prevent the members of the community from achieving a state of physical, mental and social well being.

PILLAR II - COMMUNICATIONS AND INVOLVEMENT

The second pillar is the traditional relationship of the Indian people to the Federal Government, in which the Federal Government serves as advocate of the interests of Indian communities to the larger Canadian society and its institutions, and promotes the capacity of Indian communities to achieve their aspirations. This relationship must be strengthened by opening up communication with the Indian people and by encouraging their greater involvement in the planning, budgeting and delivery of health programs.

PILLAR III - INTERRELATED HEALTH SERVICES

This third pillar is the Canadian Health System. This system is one of specialized and interrelated elements, which may be the responsibility of Federal, Provincial or Municipal Governments, Indian Bands, or the private sector. But these divisions are superficial in the light of the health system as a whole. The most significant Federal roles in this interdependent system are in Public Health activities on reserves, health promotion, and the detection and mitigation of hazards to health in the environment. The most significant Provincial and private roles are in the diagnosis and treatment of acute and chronic disease and in the rehabilitation of the sick. Indian communities have a significant role to play in health promotion, and in the adaptation of Health Services delivery to the specific needs of their community. Of course, this does not exhaust the many complexities of the system. The Federal Government is committed to maintaining an active role in the Canadian Health System as it affects Indians. It is committed to encouraging Provinces to maintain their role and to filling gaps in necessary diagnostic, treatment and rehabilitative services. It is committed to promoting the capacity of Indian Communities to play an active, more positive role in the health system and in decisions affecting their health.

These three pillars of community development, the traditional relationship of the Indian people to the Federal Government, and the interrelated Canadian Health System provide the means to end the tragedy of Indian ill-health in Canada.

REPORT OF SUBCOMMITTEE ON NFA SURGERY

DEFINITION

The term NFA Surgery means not-for-admission surgery. Other terms used are:

-out-patient surgery
-day-care surgery
-ambulatory care surgery

PRESENT STATUS

a) Rural - There is in most rural areas no shortage of beds for surgical patients and therefore little incentive to divert surgical patients from inpatient to outpatient facilities.

b) Urban - In Winnipeg, Brandon (and ? Thompson) however most inpatient surgical services are overloaded and waiting lists are becoming longer. If some procedures now done as inpatient procedures could be done on an outpatient basis, the demands for surgical beds would decrease.

CURRENT STATISTICS FOR DAY CARE SURGERY IN MANITOBA

The accompanying table (Table I) shows:

a) those procedures most commonly done as day care procedures under general anaesthesia for all Manitoba hospitals

b) the number of same procedures done as inpatient operations under general anaesthesia

c) the number of days hospitalization required by the inpatient procedure

d) the percentage of outpatients to inpatients for each procedure

POSSIBILITIES FOR EXTENSION OF DAY CARE SURGERY

a) Palo Alto Medical Centre Experience. As a cost saving measure in a prepaid insurance plan a highly organized Day Care Surgicentre has been developed at Palo Alto, California.

The enclosed list (Table 2) shows those procedures commonly performed as outpatient procedures.

b) Dept. of National Health and Welfare Ottawa Publication "Day Surgery Unit Guidelines" (Table 3) shows the suggestions of the Subcommittee on Special Services in Hospitals for outpatient surgery.

Not all surgeons would agree that all of the procedures in these tables should be done on an outpatient basis particularly when medical malpractice litigation is on the increase but most would agree that there is room for expansion of outpatient surgery.

In Manitoba the greatest experience by far with outpatient surgery is at the Winnipeg Children's Hospital where the program is under the direction of Dr. Ray Postuma. The enclosed graph (Appendix A) shows how this service has expanded since 1955.

POSSIBILITIES FOR SIMPLE EXTENSION OF CURRENT MANITOBA PRACTICES

If we refer to Table I we find that in 1983-84:

a) where the frequency of an outpatient surgical procedure exceeded 322 cases per year, there were 22 categories of operations.

b) in 8 of these categories Manitoba hospitals now do 80% of these cases as an outpatient rather than inpatient procedure (taking figures to the nearest decimal).

c) if we accept that:

1) for these operations a ratio of 80% outpatient procedure is commendable
2) cases where the frequency of the procedure is less than 322 cases per year do not contribute substantially to the overall average, then we can conclude that

d) there are 12 categories of procedures where there is room for an expansion of outpatient surgery.

e) if these 12 categories could be raised from their present levels up to 80% outpatient surgery, then a total of 37,682 days inpatient stay would be saved in Manitoba hospitals per year.

NEEDED FACILITIES TO ACHIEVE THIS GOAL

It is absolutely essential that for a successful outpatient surgical program, all facilities must be well organized. Recommendations regarding this from the National Health and Welfare Booklet Day Surgery Unit Guidelines are attached (Appendix B).

Some of the more important requirements are:

1) pre-admission evaluation, instruction and preparation of the patient
2) pre-operative anaesthesia assessment
3) a post-operative recovery room and observation area with its own staff
4) a waiting room for family
5) provision for post-operative follow-up including home nursing visits if necessary
6) other details as outlined in Appendix B

INCENTIVES TO EXPAND OUTPATIENT SURGERY

1) To the physicians

a) to free hospital beds and reduce the waiting period for patients requiring admission.
b) it is obvious that this incentive is reduced if such highly valued beds are seen to be occupied by patients who simply require nursing homes or home care by family and outpatient services

2) To the hospitals

To lower costs as has been demonstrated in Palo Alto.

3) To the Provincial Department of Health

To lower costs and permit financing of other needed facilities.

...3

4) To the Public

a) cost saving is of course also in the public interest.
b) in children there is a decided psychological benefit in remaining in familiar home surroundings. While surgery itself is traumatic, the additional trauma of separation is minimized.
c) there is a smaller risk of nosocomial (hospital induced) infection.
d) waiting periods are reduced.

In summary Day Care Surgery is already well under way in some Manitoba hospitals but there is room for expansion and formalization of the program.

This report is respectfully submitted.

L. C. BARTLETT, M.D.,
Chairman.

Committee Members:

Dr. R. Postuma
Dr. J. Ross
Dr. J. McBeath
Ms. Susan Manson
Dr. J. D. Scurrah
Ms. Sandra Ringaert
Ms. Phyllis MacDonald - Recording Secretary

TABLE I

INCIDENCE OF DAY CARE SURGERY TO TOTAL (FIRST PROCEDURE) CASES
ALL MANITOBA HOSPITALS

Description	Total	Day Care	Percent	Total Days Stay Inpatient	Total	Day Care	Percent	Total Days Stay Inpatient	Total	Day Care	Percent	Total Days Stay Inptnt.
		1981/82				1982/83				1983/84		
Dental Procedures	5,763	4,738	82.2	9,150	6,276	5,192	82.7	4,926	6,220	5,217	83.9	7,685
Cystoscopy	2,616	1,530	58.5	14,444	2,432	1,444	59.4	22,823	2,477	1,586	64.0	11,761
Dilation & Curettage	5,810	3,059	52.7	6,899	5,769	3,034	52.6	7,375	6,123	3,411	55.7	6,602
Therapeutic Abortion	1,628	1,446	88.8	532	1,677	1,490	88.8	449	1,827	1,604	87.8	468
Tubal Ligation	1,003	842	83.9	290	1,086	922	84.9	295	950	758	79.8	269
Breast Biopsy	1,698	1,213	71.4	2,211	1,713	1,205	70.3	2,609	1,573	1,148	73.0	2,235
Exc Tendon Lesion Hand	614	552	89.9	165	704	614	87.2	285	736	676	91.8	187
Circumcision	1,119	418	37.4	2,804	1,087	399	36.7	9,494	1,168	395	33.8	3,092
Hernia Repair	1,256	42	3.3	6,596	1,337	57	4.3	6,693	1,284	128	10.0	6,974
Under 12 years Tonsil- lectomy & Adenoidectomy	1,078 375	48 12	4.5 3.2	2,264 750	968 292	31 14	3.2 4.8	1,874 556	1,084 322	129 24	11.9 7.4	1,910 566
Myringotomy	1,149	881	76.7	560	1,269	1,046	82.4	975	1,428	1,180	82.6	642
Nasal Operations	501	329	65.7	654	544	337	61.9	869	577	359	62.2	916
Arthroscopy	557	344	61.8	639	696	450	64.7	689	695	448	64.4	741
Bronchoscopy	1,026	328	32.0	15,356	1,005	319	31.7	15,915	1,050	355	33.8	12,302
Esophagoscopy	371	237	63.9	2,600	420	275	65.5	6,032	448	317	70.8	2,646
Gastroscopy	2,243	1,519	67.7	12,887	2,359	1,655	70.2	13,235	2,639	1,916	72.5	15,183
Small Bowel Endoscopy	1,508	1,240	82.2	3,243	1,631	1,340	82.2	3,579	1,713	1,423	83.1	8,961
Large Bowel Endoscopy	3,341	2,674	80.0	9,205	4,062	3,230	79.5	12,896	4,118	3,346	81.3	14,822
Sigmoid Endoscopy	994	792	79.7	2,332	863	662	76.7	7,759	942	764	81.1	3,667
Haemorrhoid Procedures	678	122	18.0	3,670	606	71	11.7	3,157	649	73	11.2	3,514
Varicose Vein Procedures	487	35	7.2	2,441	436	37	8.5	1,955	486	51	10.5	2,262

SURGICAL PROCEDURES COMMONLY PERFORMED AS OUTPATIENT SURGERY

General Surgery:

Baker's cyst, excision
Breast masses, excision
Cervical node biopsy
Foreign body, removal
Frenulectomy - tongue
Hemorrhoidectomy
Thrombotic hemorrhoidectomy
I & D abscess
Inguinal herniorrhaphy
Lipoma, excision
Muscle biopsy
Excision of draining sinus tract
Pilonidal cystectomy
Rectal polypectomy
Sebaceous cyst, excision
Skin lesions, excision (granuloma)
Thyroglossal duct cyst
Umbilical herniorrhaphy
Varicose vein ligation, with or without stripping
Fistulectomy

Gyn:

Bartholin cystectomy
Cervical amputation (Stermdorf)
Cryotherapy (alone)
Cryotherapy with biopsy and/or D & C
Culdoscentesis
Culdoscopy
D & C
Exam under anesthesia
Hymenotomy
Hysterosalpingogram
Laparoscopy - Diagnostic or Sterilization
Cervical cone - hymenectomy
Perinorrhaphy
Removal IUD

Eye:

Chalazion
Discission
Ectropian & entropian
Eye exam
Eye muscle operation
Iridectomy
Lacrimal duct probing
Prolapsed iris, excision
Pterygium
Insertion of glass tube into lacrimal duct
Reconstruction of lacrimal duct

Endoscopy:

Bronchoscopy
Cystoscopy
Cystoscopy & retrograde
Esophagoscopy
Gastroscopy
Laryngoscopy
Proctoscopy

Orthopaedic:

Arthroscopy
Bunion operation
Bursae, removal of (Olecranon)
Carpal tunnedl decompression
Closed reduction, without x-rays
Closed reduction fracture, with x-rays
Finger or toe nails, removal
Ganglion
Hammertoes with tenotomies and resection of bones
Hand surgery
Hardware, hip, removal
Kidney cannula, revision
Manipulation of joints
Manipulation of joints with x-rays
Metatarsal heads, excision
Morton's neuroma
Nerve repair
Phalangectomy
Plantar wart, excision
Plate or screws, except hip, removal
Repair of medical ligament, knee
Stitches, removal
Tendon repair
Tenosynovectomy
Tenotomy, hand or foot
Open reduction fractures, without x-rays
Open reduction fractures, with x-rays
Cast change with x-rays
Excision of foreign body - granuloma
Release of tendon sheath
Ulnar nerve repair

Neurosurgical:

Carpal tunnel
Alcohol injection of nerve and coagulation of nerves for control
Intercostal neurectomy
Excision neuroma
Morton's neuroma
Ulna nerve release

Ear, Nose and Throat:

Adenoidectomy & myringotomy
Antral puncture, with or without irrigation
Arch bars, removal
Closed reduction nose or zygoma
Inferior turbinate fracture
Laryngoscopy
Myringotomy with or without tubes
Otoscopy, with or without removal of foreign body
Nasal Polypectomy
Septal reconstruction, SMR
Ethmoidectomy
Tonsillectomy, with or without adenoidectomy
Tympanoplasty
Wiring of fractured jaw
Rhinoplasty
Stapedectomy

Urological:

Circumcision
Cystoscopy
Cystoscopy & Retrograde
Dorsal slit
Meatotomy
Prostate, biopsy
Urethral dilation
Vasectomy

Plastic Surgery:

Augmentation mammoplasty
Blepharoplasty
Dermabrasion
Otoplasty
Rhinoplasty
Small scars, excision
Small tattoo, excision

TABLE 3

POSSIBLE DAY SURGICAL, MEDICAL AND DIAGNOSTIC PROCEDURES

General Categories of Procedures

It is recommended that a system of broad categorization be used to provide a guide to possible elective day surgical, medical, and diagnostic procedures. The following categories are suggested:

1. Elective surgical, dental, and diagnostic procedures that require the use of less than one and one-half hours of general anaesthesia.

2. Procedures under local anaesthesia that require post-operative observation.

3. Endoscopic procedures under general or local anaesthesia.

The following comprehensive list indicates those procedures that are known to have been performed on a day surgery basis in various facilities. This list is for reference only. Policies to determine which procedures can be safely carried out in the elective day surgery unit should be established in each facility.

A. SURGICAL PROCEDURES

General Surgery, Chest Surgery

Abscess, incision and drainage
Baker's cyst, excision
Breast masses, excision
Bronchoscopy
Carbuncle, excision
Cervical node biopsy
Colonoscopy
Colostomy revision
Debridements
Fistulectomy
Foreign body, removal
  (with or without X-ray)
Frenulectomy, tongue
Gastroscopy
Haemorrhoidectomy
Haemorrhoidectomy, thrombotic
Herniorrhaphy, inguinal
  (infant or adult - unilateral or bilateral)
Herniorrhaphy, umbilical
Laparoscopy
Lipoma, excision
Lymph node biopsy
Mediastinoscopy
Muscle biopsy
Orchidectomy
Orchidopexy
Pilonidal cystectomy
Polypectomy, rectal
Rectal biopsy
Scalene node biopsy
Skin lesions, excision
Thyroglossal duct cyst
Varicocelectomy
Varicose vein ligation
Varicotomy

Gynaecology

Abortion, therapeutic
Bartholin cystectomy
Cervical amputation (Sterndorf)
Cervical cone
Cautery vaginal cyst
Colpotomy, diagnostic
Condylomata Acuminata (treatment of)
Cryotherapy (alone)
Cryotherapy with biopsy
Culdocentesis
Culdoscopy
Dilation and curettage
Episiotomy
Excision adhesions of clitoris
Examination under anaesthesia

Hymenotomy
Hysteroscopy
Hysterosalpingogram
Intrauterine contraceptive device, removal
Laparoscopy
Perineorrhaphy
Polypectomy, cervical
Saline injection intrauterine therapeutic
Tubal coagulation or ligation
Vulva biopsy

Oral Surgery

Cystectomy
Fracture, closed reduction, uncomplicated
Odontectomy, uncomplicated
Odontectomy, surgical
Periodontic surgery (full or partial)

Ophthalmology

Aspiration of aqueous
Biopsy, conjunctiva or cornea
Cataract by phakoemulsification
Canthus excision
Curettage or cauterization of corneal ulcer
Chalazion
Cryoretinopexy
Cryotherapy
Discission
Ectropion and entropion
Enucleation
Hordeolum, incision and curettage
Iridectomy
Keratotomy
Lacrimal duct probing or reconstruction
Myotomy - recession or resection
Photocoagulation
Pterygium
Strabotomy, pediatric
Tarsorrhaphy
Therapeutic retrobulbar injections

Orthopedic and Neurosurgical

Arthrotomy, meniscectomy
Arthrodesis (phalanges, other joints)
Arthroplasty (phalanges, other joints)
Arthroscopy
Bone graft
Bone reconstruction
Bunion operation
Bursae, removal of (olecranon)
Capsulectomy
Carpal tunnel decompression
Carpal tunnel ligament release
Cast change with manipulation
Exostosis, excision
Fasciectomy (finger, palm)
Fingernail or toenail removal
Fracture, closed reduction (with or without X-ray)
Ganglionectomy
Hammertoes with tenotomies and resection of bones
Hardware, removal
Hardware, removal, hip
Injection of intervertebral disc
Intercostal neurectomy
Manipulation of joints (with or without X-ray)
Medial ligament, knee repair of
Metatarsal heads, excision
Morton's neuroma
Nerve repair
Neuroma (other)
Olecranon spur, excision
Phalangectomy
Plantar wart, excision
Tendon repair
Tenosynovectomy
Tenotomy, hand or foot

Trigger finger release
Torticollis repair
Ulnar nerve transfer

Otolaryngology

Adenoidectomy and myringotomy
Antral puncture
Arch bars, removal or application
Branchial arch appendages, excision
Bronchoscopy
Cystoscopy
Esophagoscopy
Ethmoidectomy
Excision, foreign bodies
Excision, lesions, skin tags, cysts
Excision, parotid and submaxillary stones
Haemangioma, nostril
Inferior turbinate fracture
Jaw, wiring of
Laryngoscopy
Laryngeal polypectomy
Limited rhinoplasty
Mastoidectomy
Myringoplasty
Myringotomy with or without tubes
Nasal polyp, removal
Nose, closed fracture reduction
Otoscopy
Pedicle flap, transfer
Polypectomy, nasal
Septal reconstruction
Stapedectomy
Sub-mucous resection
Tonsillectomy, with or without adenoidectomy
Tympanoplasty
Zygoma, reduction

Cyst excision
Cleft lip repair
Dermabrasion (partial or full)
Gynecomastia, excision
Hair transplantation
Mammoplasty, augmentation or revision
Meloplasty
Otoplasty
Rhinoplasty
Rhytidoplasty
Scar revisions and relaxations
Skin grafts, minor
Skin lesions, excision, minor
Xanthoma, excision

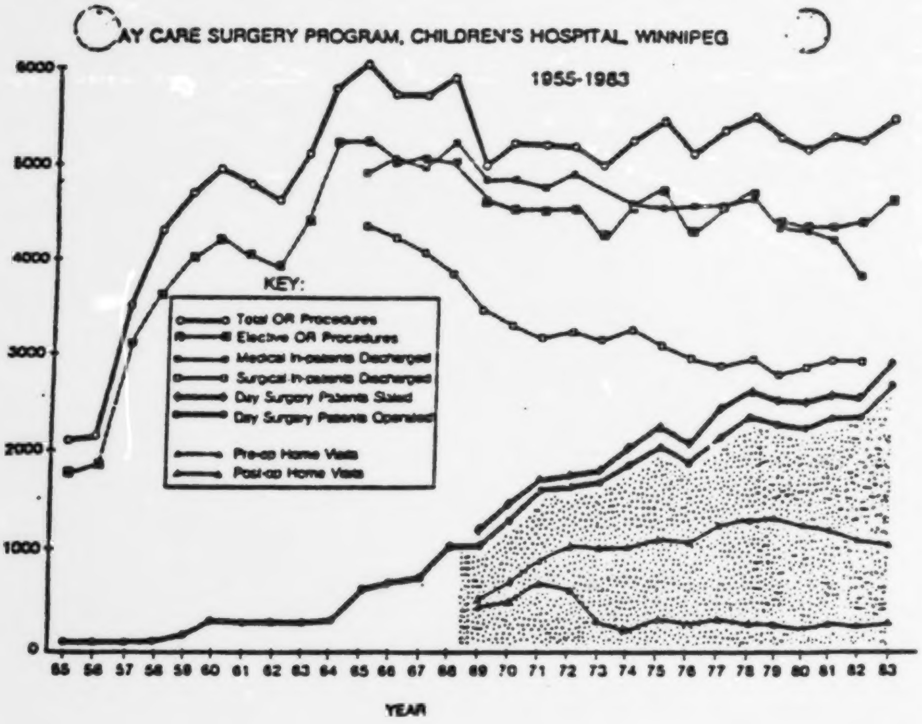
Urology

Caruncle, excision
Circumcision
Cystectomy, Skene's Duct
Cystoscopy
Dorsal slit
Fulguration of bladder neck
Hydrocelectomy
Inguinal/Scrotal abscess, incision and drainage
Litholapaxy
Meatotomy
Prostate biopsy
Retrograde studies (i.e. Pyelograms)
Testes, excision
Urethral dilation
Urethroscopy
Vasectomy
Vasograms

B. MEDICAL AND DIAGNOSTIC PROCEDURES

Bone marrow aspiration and/or biopsy
Cardioversion
Electroshock therapy
Esophogeal dilatation
Gastroscopy
Laparoscopy
Liver biopsy
Myelogram
Paracentesis
Proctosigmoidoscopy
Renal biopsy
Spinal tap

APPENDIX A


AY CARE SURGERY PROGRAM, CHILDREN'S HOSPITAL, WINNIPEG
1955-1983
KEY:
Total OR Procedures
Elective OR Procedures
Medical In-patients Discharged
Surgical In-patients Discharged
Day Surgery Patients Slated
Day Surgery Patients Operated
Pre-op Home Visits
Post-op Home Visits
6000
5000
4000
3000
2000
1000
0
55
56
57
58
59
60
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83
YEAR

APPENDIX B

Classification of Delivery Modes

1. A Self-Contained Day Surgery Unit

Such a unit will be self-contained either within the established hospital or in close proximity to the hospital. Either type of unit in this category would have its own dedicated operating room and recovery area(s). The unit may also have areas for reception and changing, a room for post-procedural observation, and a discharge area. Such units should be dedicated to elective day surgery and selective diagnostic procedures only.

2. An Integrated Shared Facility

Such a unit would utilize the hospital's existing main surgical suite and recovery rooms on an integrated shared basis while ensuring that adequate provisions are made for pre-operative, operative, and post-operative care, and discharge and follow-up according to its own resources.

It is recommended that, whenever possible, designated and suitably staffed areas be available for reception and post-recovery. The provision of a separate, appropriately staffed post-recovery room area allows observation of the patient's condition prior to discharge, prevents interference with the main surgical suite and recovery room functions, and promotes continuity of patient care.

3. A Multipurpose Facility

In facilities where the potential volume of surgery to be performed is not large enough to establish a separate service, elective day surgery can be performed as part of the normal surgical work-flow of the hospital. Under these circumstances, special attention must be paid to admitting and discharge policies and procedures, and mechanisms for post discharge and follow-up care must be established.

Limiting Factors

Elective day surgery should not be equated with emergency short-stay surgery which may entail increased hazards due to recent food intake and a possible lack of time for a complete pre-operative assessment.

There are a number of variables which will influence the performance of procedures on a day surgery basis. These variables will be of varying importance depending upon the physical structure of the Unit and the experience and skill of those working in the Unit.

1. Patient Selection

Patients suitable for day surgery are those who are in good health or those who have no more than a mild to moderate systemic disturbance caused by either the condition that necessitates the procedure or any other pathophysiological process (for example, mild diabetes, slight or limited organic heart disease, controlled epilepsy, mild asthma).

Normally patients with a severe systemic disturbance or disease would not be considered as suitable candidates for day surgery. However, under special circumstances, day surgery may be appropriate for these patients. For example, a patient receiving chemotherapy may be under less risk of exposure to infection if necessary procedures are carried out on a day surgery basis.

The patient must have the ability to understand and comply with post-operative instructions, and must be willing to accept the procedure on an outpatient basis.

2. Anaesthetic Services

Following the end of the anaesthetic, adequate time must be allowed for recovery to "street fitness" before the patient is discharged from hospital. To allow this, as a general rule the general anaesthetic itself should not last longer than one and a half hours.

Care should be taken in choosing patients over the age of 60 for general anaethesia, as recovery may be prolonged. Small children, including babies, may be anaesthetized for short procedures, but premature babies, during the first six months of life, are not suitable candidates for day surgery.

3. Additional Considerations

a) Informed patient consent: the patient should be made aware of alternatives as part of the informed consent process.

b) Procedures unsuitable for day surgery:

- procedures requiring specialized post-operative nursing, pain control by injected narcotic, or complicated post-operative care;
- procedures commonly involving a significant blood loss.

c) Post discharge arrangements:

- The adequacy of the home environment for after-care should be known in advance, having regard to the specific surgical procedure. Adequacy is assessed in terms of physical accommodation and availability of personal support at home. If the home environment is not adequate, alternative arrangements must be established. If this is not possible, the patient should be admitted to inpatient care.

d) Distance

The distance to be travelled after discharge and the method of transportation available to the patient should be known when assessing the patient's suitability to undergo a specific procedure on an day surgery basis.

GUIDELINES

1. PATIENT LOAD

The minimum patient load required to make day surgery a viable service is dependent upon the type of program established. To estimate the probable patient load operating room utilization statistics with types of procedures performed during the preceding year can be analyzed and the number of procedures suitable for day surgery identified.

Experience of hospitals with day surgery programs has shown that of the total number of all operations, 35-50 per cent may be performed on a day surgery basis. For a self-contained unit with two operating rooms a minimum of 16 patients a day would be required for a viable service. The current workload of self-contained day surgery units in major centres in Canada varies between 2000 and 3000 cases per operating room per year.

In establishing an integrated shared facility, consideration should be given to the impact that Day Surgery may have on the multipurpose utilization of the operating room suite and recovery rooms in terms of potential increases in time/space. On the average an operating room can accommodate 1200-1500 inpatient procedures or 2000-3000 day surgery procedures per year.

2. BED REQUIREMENTS

In-patient beds are not a requirement for a day surgery program. However, there must be provision made to allow immediate admission to an inpatient service whenever this is indicated. Provision should be made for holding patients in post-operative recovery rooms and also later in day unit observation areas. The number of day unit stretcher/beds required by the unit will vary with the volume of work in the unit but will be approximately one stretcher/bed for every two cases.

3. ADMINISTRATIVE POLICY, PROCEDURES AND CONTROL

A day surgery unit multidisciplinary advisory committee should be formed which would normally include representatives from surgery, anaesthesiology, nursing and other disciplines as appropriate. The role of this Committee would be to coordinate the input of the various services, to plan, review and evaluate, and to advise the medical advisory committee and the administration on the operation of the program. An existing hospital committee with similar composition may assume this role.

3.1 General Clinical Direction

General clinical direction should fall under the jurisdiction of a hospital designated physician with appropriate skills.

3.2 Policies and Procedures[1]

In addition to the normal policies and procedures established for hospital operating rooms, the following policies should also be adopted:

1. Pre-admission history, physical evaluation and necessary laboratory tests should be done as close as reasonably possible to the date of surgery and must be available to the anesthetist and the surgeon before commencement of the operation.

2. Pre-admission written instructions to patients undergoing general anaesthesia, and other written instructions specific to certain procedures should be given to the patient at the time of the pre-admission evaluation. (See example, Appendix II p. 20.)

3. Prior arrangements should be made with the local home care program, where home care is indicated and available.

4. Responsibility with relation to patient selection lies with the designated physician. However, it is the anaesthetist's responsibility to make decisions relative to the desirability of administering a general anaesthetic for a particular patient and procedure.

5. Standard Operating Room and Anaesthesia Department policies must be maintained in the elective day surgery unit.

6. A record of procedures carried out must be included in the patient's permanent medical record.

7. Appropriate post-operative care guidelines and discharge criteria must be established in the unit.

8. The patient must be discharged on a physician's order.

9. The patient should be discharged from the unit only if accompanied by a responsible adult.

10. Discharged patients must be provided with written instructions for home convalescence, and directions for reaching assistance should complications arise.

11. Twenty-four hour emergency services should be available to the patient:

    - Patients should be provided with a contact phone number to reach the responsible physician.

See also Appendix III, "Guidelines for Policies and Procedures for Special Services in Hospitals".

- Patients should be instructed to contact the hospital's emergency service if they require assistance and are unable to reach the physician.

- a home visiting service, that is dedicated to day surgery or part of a home care program, may be utilized.

12. In some units the exchange of phone calls during the immediate post-operative period between the patient and/or family and the unit staff has been found to be beneficial to both parties.

13. The results of the patient's follow-up care by the physician outside of the hospital should be recorded on the patient's hospital record.

3.3 Responsibilities of Unit Staff

Policies regarding the relationship, duties and responsibilities of all members of the unit staff must be clearly defined in writing.

STAFF ESTABLISHMENT AND COVERAGE

One of the purposes of establishing a day surgery unit will be the achievement of considerable staffing cost economies when compared to the same services offered on a 24-hour in-patient basis. Staffing requirements for the unit are on a limited basis of eight to twelve hours a day, usually for a five day week. Flexible staffing patterns such as staggered or split shifts can be used to ensure that sufficient staff are available to adequately cover the peak periods when patients are being admitted and discharged. Nursing staff requirements will depend on patient load, case mix, and the layout and administrative patterns of the unit. Whatever staffing pattern is used, adequate nursing coverage must be provided.

5. STAFF TRAINING AND QUALIFICATIONS

Professional personnel should be governed by the same regulations, with respect to credentials and delineation of privileges, that apply to the inpatient surgery services.

Nursing staff should consist of registered nurses who have surgical nursing skills. Nurses working in the operating and recovery rooms should have appropriate training in these areas.

Resources should be available for staff orientation and in-service education.

6. SPECIFIC SUPPORTING DEPARTMENTS AND SERVICES

The various services and/or departments involved may be:

- hospital operating room support services;
- inpatient services for patients with complications who need to be admitted;
- home care program or hospital day surgery nursing visit program to provide support services to the patient on discharge;
- outpatient department for pre-admission evaluation;
- admitting services;
- social services;
- medical record services;
- dietary services;
- laboratory department;
- volunteer services.

7. SPACE ALLOCATION, UTILIZATION AND SPECIAL DESIGN FEATURES[1,2]

Flexibility is a key factor in meeting changing workloads. The Unit must have the capacity for adequate:

- reception
- pre-operative preparation,
- post-operative observation,
- changing, locker and washroom facilities,
- waiting room for relatives and friends.

In addition, self-contained units will require operating rooms, post-anaesthetic recovery room, clean and soiled utility rooms, office space, staff washrooms, change lockers and lounge areas.

Consideration should also be given to the fact that the integrated shared facility and the multipurpose facility will create an additional workload for the existing operating and recovery rooms and space/time requirements in this area may therefore change.

8. EQUIPMENT

The self-contained unit should be equipped according to the standards required for hospital operating and recovery rooms.

Emergency oxygen, suction and resuscitation equipment, as well as drugs, intravenous solutions and appropriate surgical supplies should be available in the pre- and post-operative areas.

9. RELATIONSHIP WITH OTHER DEPARTMENTS AND SERVICES

If possible, the service should be established in such a way that easy access for elective day surgery patients is provided. Proximity of the observation area to the operating and recovery rooms is important.

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[1] Opinions on design information may be obtained from other sources, including: Design Considerations for Special Care Units in Hospitals, 1978, and Evaluation and Space Programming Methodologies, 1980. Available from: Health Facilities Design Division, Health Resources Directorate, Health Services and Promotion Branch, Department of National Health and Welfare Canada.

[2] For definitions of net and gross areas please refer to: Floor Area Measurement for Health Facilities. Available from: Health Facilities Design Division, Health Resources Directorate, Health Services and Promotion Branch, Department of National Health and Welfare Canada, 1978.

REPORT

OF THE OBSTETRIC SUBCOMMITTEE

OF THE

HEALTH SERVICES REVIEW COMMITTEE

JANUARY 16, 1985

MEMBERS

DR. R. A. LIVINGSTONE	Chairman
DR. C. BECKER	Director of Maternal and Child Health, Manitoba Department of Health
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FOREWORD

In addressing the various issues and in making the recommendations in this report the committee was very aware of the scope and complexity of each issue discussed. For this reason we did not refer extensively to the current literature nor develop an extensive bibliography but rather tried to apply our collective knowledge and understanding of contemporary reproductive medicine to improving the quality and efficiency of delivery of health care in our own provincial situation. We are aware that many of the recommendations are general and non-specific and will require further detailed work if they are to be taken up and implemented. The committee applauds the Minister in his initiative in developing and maintaining a dialogue with professionals of the province on the broad issues of health care. We would urge that this dialogue continue through the medium of appropriate ad hoc advisory committees as each recommendation is studied in depth and implemented.

R. A. LIVINGSTONE, M.B.
Chairman,
Obstetric Subcommittee of the
Health Services Review Committee

INTRODUCTION

In June of 1984 the Provincial Minister of Health, the Honorable L. L. Desjardin, met with a number of representatives of the medical profession, University, College of Physicians and Surgeons and hospital administration. The purpose of this meeting was "to explore ways in which government, in partnership with the profession, can refocus our health care system from a sickness model to one of health promotion within the limits the province can afford". It was pointed out at this meeting that an increasingly aging population will increase the costs of health care enormously over the next ten years with little prospect of any significant increase in funding. It is therefore incumbant on us, as professionals, to work with government in priorizing and planning to best use the dollars available where they will be most needed. To assist in this task the minister set up a Health Services Review Committee with representation from the M.M.A., M.H.S.C., hospital administration, the university, M.A.R.N., the College of Physicians and Surgeons and the Department of Health.

The terms of reference of this committee are as follows:

1. To identify major cost centers and explore the possiblity of consolidation.
2. To look for alternatives to inpatient service delivery systems (for example N.F.A. or Ambulatory Care Services).
3. To review current bed allocations and the appropriateness of the numbers and utilization of this resource.
4. To review criteria for hospital admissions in both Winnipeg and rural hospitals.

The commitee identified 15 areas which they felt required considerable review; subcommittees (of which the Obstetric Subcommittee was one) were established to look at these areas in depth and to make recommendations.

The Obstetric Subcommittee adopted the following terms of reference:

1. To identify categories of disease/treatment for which there is no alternative to hospitalization.
2. To identify categories of disease/treatment for which there are alternatives to hospitalization and to indicate what resources are necessary to permit a shift of emphasis towards ambulatory care.
3. To make these recommendations within the constraints of a relatively fixed budget, exercising prudent fiscal restraint.
4. To ensure that all proposals are consistent with efficatious health care.

Bearing in mind these terms of reference, the committee, at its first meeting developed a list of topics which members felt were most deserving of study. These were as follows:-

1. Antepartum bed utilization and criteria for ambulatory management/ admission.
2. Postpartum bed utilization and backup services necessary to encourage early discharge.
3. Neonatology and neonatal intensive bed requirements.
4. Hostel accommodations for out-of-town patients.
5. The expanding role of the nurse in reproductive health care.
6. Obstetric bed distribution and utilization in Winnipeg.
7. Obstetric bed distribution and utilization in rural areas.
8. Gynecology and the more effective use of N.F.A.
9. The consolidation of the various perinatal committees.
10. Professional and patient education programs.
11. Definition of levels of obstetric and neonatal care.

Over a period, from August 29th to December 14th, 1984, the Obstetric Subcommittee met 8 times at approximately 2 week intervals and succeeded in addressing each of these topics in turn.

OVERVIEW

In the fairly extensive report which follows, some 51 recommendations have emerged from the deliberations of this subcommittee. Many of these recommendations have already been made by the Community Task Force and a few are under active consideration for implementation. It may be of help to provide an overview of the major thrusts of the report which follows. This summary has been taken from the completed report by the committee chairman.

- There is a need to strengthen and improve coordination of the community base in the area of public health nursing if better and more efficient use is to be made of our acute hospital beds.

- Links between hospital and community care must be strengthened by closer cooperation between public health nurses and hospital personnel.

- Development of alternatives to hospital care should be encouraged by adequate funding of hostels for out-of-town patients, home care programs and early discharge and N.F.A. programs.

- Improved maternal and neonatal transport and improved accessibility of ultrasound and fetal assessment services is needed in both urban and rural areas.

- Ongoing and comprehensive education of all consumers and providers of health care must be established to encourage more effective and efficient utilization of health care resources.
  Professional education should be adequately funded and coordinated through a proposed Manitoba Perinatal Education Program functioning within the context of a Provincial Perinatal Program.
  Patient education should be standardized and regulated so that adequate, up to date information is available to all patients throughout prenatal and postnatal periods; coordination and monitoring of such a program would ideally be a function of a steering committee of a Provincial Perinatal Program.

- Deficiencies in neonatal care need to be addressed, eg. an adequate number of N.I.C.U. beds must be provided for the province; a comprehensive, longterm follow-up program for high risk neonates must be provided; a comprehensive neonatal transport system and assurance of adequately trained personnel in all delivery units for neonatal resuscitation and stabilization is required.

- The setting up of an ad hoc committee is suggested to study and make recommendations on the expanded role of the nurse in the delivery of reproductive health care.

- Further consolidation of obstetric beds within the city of Winnipeg can be justified on grounds of cost effectiveness and efficiency.

- A plea is made for consolidation of the numerous perinatal committees into one body responsible for advising government within the context of a well structured and coordinated provincial perinatal program.

ANTEPARTUM BED UTILIZATION

It is not uncommon for patients with a number of high risk obstetric problems to be confined to hospital for prolonged periods during the antepartum months. While this is often unavoidable a large number of obstetric beds are blocked, patients are generally unhappy and there is a significant element of family disruption as a result. Although many antepartum problems will continue to require hospitalization, it is now believed possible to manage a number of these patients on an ambulatory basis given patient compliance and appropriate backup service. A pilot project is currently being introduced at St. Boniface General Hospital involving a group of antepartum patients with pregnancy induced hypertension managed on this basis. Selected patients in other disease categories may also be suitable for management in this way, eg. gestational diabetes, antepartum hemorrhage, oblique lie, spontaneous premature rupture of membranes, hyperemesis gravidarum and repeated spurious labour.

High risk antepartum patients managed on an ambulatory basis will fall into one of three categories.

1. Those requiring formal visiting and monitoring by an R.N. in the home on a regular basis.
2. Those where adequate monitoring can be provided by free access to out patient monitoring facilities.
3. Those where the patient can monitor her own condition given the proper equipment.

The committee can see a significant potential for saving hospital beds in this group of patients by ambulatory management but feels that a number of backup services and conditions must be in place to allow such a program to be operated safely.

RECOMMENDATIONS

1. PHYSICIANS SHOULD BE ENCOURAGED TO MANAGE AS MANY ANTEPARTUM PROBLEMS AS POSSIBLE ON AN AMBULATORY BASIS WHERE THIS CAN BE DONE WITH SAFETY USING THE SERVICES IDENTIFIED IN THE FOLLOWING RECOMMENDATIONS.

2. THE COMMUNITY BASED HIGH RISK ANTEPARTUM HOME CARE PROGRAM CURRENTLY OPERATING AT ST. BONIFACE, (OFFERING FORMAL VISITING AND MONITORING BY APPROPRIATELY TRAINED R.N.s IN THE HOME) SHOULD BE FURTHER DEVELOPED TO COVER A RANGE OF ANTEPARTUM PROBLEMS, INCLUDING THOSE LISTED ABOVE.

3. FREE ACCESS TO OUTPATIENT PERINATAL ASSESSMENT FACILITES MUST BE MADE AVAILABLE TO PATIENTS THROUGHOUT THE PROVINCE THROUGH
   i) FETAL ASSESSMENT UNITS STAFFED WITH APPROPRIATELY TRAINED NURSES AND SUPERVISED BY OBSTETRICIANS IN WINNIPEG AND REGIONAL CENTRES.
   ii) FURTHER DEVELOPMENT OF THE ANTEPARTUM OUTREACH PROGRAM UTILIZING VISITATION BY R.N. AND OBSTETRICIAN TO SELECTED RURAL AREAS. A STUDY DONE IN THE ISLAND LAKE AREA DEMONSTRATES COST EFFECTIVENESS OF THIS PROGRAM (APPENDIX 1).
   iii) HOSTEL ACCOMMODATION IN WINNIPEG WITH FREQUENT VISITS TO FETAL ASSESSMENT UNITS IN EITHER THE HEALTH SCIENCES OR ST. BONIFACE FOR PATIENTS FROM MORE REMOTE AREAS.

   COMPLETE COVERAGE OF THE PROVINCE COULD BE PROVIDED BY A COMBINATION OF THESE THREE APPROACHES DEPENDING ON LOCAL RESOURCES AND GEOGRAPHIC LOCATION.

   THE COMMITTEE BELIEVES THAT FETAL ASSESSMENT BY REAL TIME ULTRASOUND SHOULD ALWAYS BE DONE AS PART OF A MORE GENERAL PERINATAL ASSESSMENT AS ULTRASOUND FINDINGS TAKEN IN ISOLATION MAY BE MISLEADING. THIS SHOULD BE THE RESPONSIBILITY OF AN INDIVIDUAL WITH SUFFICIENT OBSTETRIC EXPERIENCE TO PROVIDE

CONSULTATIVE PERINATAL ADVICE AND EDUCATION.

4. DIABETES EDUCATION AND MONITORING PROGRAMS SHOULD BE AVAILABLE AND FREELY ACCESSABLE TO ALL WOMEN, PREGNANT OR NON-PREGNANT, AT BOTH TERTIARY CARE CENTRES AND IN REGIONAL CENTERS. PROGRAMS DEALING WITH PREGNANT DIABETICS SHOULD BE STAFFED BY INTERNISTS WHO HAVE TRAINING, KNOWLEDGE, EXPERIENCE, AND A SPECIAL INTEREST IN MANAGING DIABETES IN PREGNANCY.

5. THE AVAILABILITY OF ULTRASOUND SERVICES MUST BE IMPROVED TO ALLOW FOR MORE FREE AND IMMEDIATE ACCESS, THUS AVOIDING THE NECESSITY OF ADMITTING PATIENTS TO HOSPITAL TO HAVE ULTRASOUND DONE. IN THIS REGARD THE CURRENT PLAN TO EXPAND ULTRASOUND FACILITIES IN THE PROVINCE MUST BE ACTIVELY PERSUED.

6. FUNDING MUST BE PROVIDED FOR EQUIPMENT FOR SELF-MONITORING PROGRAMS (EG. ELECTRONIC SPHYGMOMANOMETER AND GLUCOMETER).

7. HOSTEL ACCOMMODATION SHOULD BE MADE AVAILABLE IN CLOSE PROXIMITY TO THE TWO TERTIARY CARE HOSPITALS (AND PERHAPS IN ASSOCIATION WITH SOME REGIONAL HOSPITALS) AS AN INSURED SERVICE. IT IS RECOMMENDED THAT THESE HOSTELS SHOULD BE OF AN APARTMENT STYLE, WITH A LARGE DEGREE OF PATIENT AUTONOMY. PRENATAL EDUCATION AND SOCIAL SERVICES SHOULD BE AVAILABLE TO PATIENTS IN THESE SITUATIONS. FOR DIABETIC PATIENTS, DIETARY SERVICES SHOULD BE AVAILABLE EITHER IN THE HOSTEL OR BY ALLOWING THE PATIENT ACCESS TO THE CAFETERIA AND DIETARY SERVICE IN THE NEARBY HOSPITAL. THIS HOSTEL WOULD BE LARGELY FOR THE USE OF DISPLACED RURAL PATIENTS AND WOULD AVOID THE NECESSITY OF USING HOSPITAL BEDS FOR BOARDING PURPOSES.

8. A PERINATAL AIR AND GROUND AMBULANCE EVACUATION SYSTEM SHOULD BE MADE AVAILABLE THROUGHOUT THE PROVINCE FOR MATERNAL TRANSFER AND FOR TRANSPORT OF THE NEONATE WHEN THE DELIVERY OF A COMPROMISED BABY IN A RURAL AREA HAS BEEN UNAVOIDABLE.

9. PATIENT EDUCATION - FOR HIGH RISK ANTEPARTUM PATIENTS WHO ARE

TO BE FOLLOWED IN THE HOME OR HOSTEL ENVIRONMENT, PROVISION MUST BE MADE FOR DETAILED PATIENT EDUCATION IN THE MOST EFFICIENT FASHION, PERHAPS WITH THE ASSISTANCE OF NURSE EDUCATORS AND A COMPREHENSIVE SERIES OF VIDEO TAPES.

10.PROFESSIONAL EDUCATION - THERE MUST BE A COORDINATED APPROACH TO CONTINUING PROFESSIONAL EDUCATION OF PHYSICIANS AND NURSES TO ENSURE HIGH STANDARDS OF PATIENT CARE AND TO ENCOURAGE EFFICIENT UTILIZATION OF SERVICES AND RESOURCES WITHIN THE CONTEXT OF A PROVINCIAL PERINATOLOGY PROGRAM. FINANCIAL RESOURCES MUST BE IDENTIFIED TO SUPPORT SUCH A CONTINUING PROFESSIONAL EDUCATION PROGRAM.

POSTPARTUM CARE AND BED UTILIZATION

1. Essentials of Postpartum Care

The committee believes the essentials of adequate postnatal care are as follows:

i) An opportunity for recovery from the physical stress of childbirth for a minimum of 48 hours within the hospital environment.
ii) Medical surveillence for postpartum problems during this period.
iii) Education and support by nurses with experience and training in reproductive care.
iv) Facilitation of bonding.

RECOMMENDATION

THE ESSENTIALS OF POSTNATAL CARE, AS DEFINED IN THIS REPORT, SHOULD BE AVAILABLE TO ALL PATIENTS ON THE BASIS OF NEED, IRRESPECTIVE OF SOCIAL CLASS OR CULTURAL BACKGROUND.

2. Cost Effectiveness of Postpartum Units

The committee feels that unnecessary expense may be caused by the provision of the same high level of nursing care to all postpartum patients, despite the fact that many postpartum patients can attend to their own needs. Patients may therefore be separated into two groups.

i) Patients with normal uncomplicated vaginal delivery who will require a minimum level of medical and nursing care and a lower nurse/patient ratio. These patients (while still in hospital) could be provided with a more hostel style environment permitting a certain amount of self help, eating at tables, ambulation, etc. Nurses should be R.N.s with skills in reproductive care and education. Fewer nurses would be necessary in such a unit and their main role would be education.

ii) Patients who have had cesarean section or significant complications in association with delivery will require a higher level of nursing and medical care; this will require a more conventional acute care hospital bed and a higher nurse/patient ratio.

Integrated family centered care should be provided at both levels to facilitate bonding and education.

RECOMMENDATIONS

1. CONSIDERATION SHOULD BE GIVEN TO REDUCING THE COST OF INHOSPITAL POSTPARTUM CARE BY DIVISION INTO TWO LEVELS AS FOLLOWS:

    i) PROVISION OF A MINIMUM LEVEL OF MEDICAL AND NURSING CARE FOR NORMAL POSTPARTUM PATIENTS ALLOWING THEM TO RECOVER FROM THE PHYSIOLOGICAL EVENTS OF LABOUR WITH EMPHASIS ON EDUCATION AND HEALTH PROMOTION. THE ENVIRONMENT SHOULD BE OF AN AMBULATORY NATURE WITH EMPHASIS ON SELF HELP, ROOMING IN, INTEGRATED FAMILY CENTERED CARE, BUFFET DINING, ETC. FEWER NURSES WILL BE REQUIRED BUT THEY SHOULD REMAIN HIGHLY SKILLED IN PERINATAL EDUCATION.

    ii) PROVISION OF A HIGHER LEVEL OF MEDICAL/NURSING CARE WITH A MORE CONVENTIONAL NURSE/PATIENT STAFFING RATIO FOR PATIENTS HAVING COMPLICATED DELIVERIES.

2. POSTPARTUM CARE AND EDUCATION IN HOSPITAL PRIOR TO DISCHARGE SHOULD BE PROVIDED BY DEDICATED NURSING PERSONNEL. STEPS MUST BE TAKEN TO ENSURE THE EDUCATION OF NURSES TO CARRY OUT THESE SPECIALIZED FUNCTIONS IN MATERNAL AND CHILD HEALTH.

3. Postpartum Length of Stay

Standard postpartum stay in hospital for mother and baby has declined in this county from 10 days (in years past) to 4 days for uncomplicated delivery. In many U.S. centers the standard postpartum stay is 48 hours. In some centers in the U.K. patients are discharged to the care of the district nurse as early as three hours following normal delivery. Early discharge programs such as these have attractions for many mothers allowing them an early return to the home environment. It also appeals to health care providers in that saving realized can be applied in other areas of emerging need.

An Early Discharge pilot program was instituted at St. Boniface General Hospital in 1983. Patients were offered the option of discharge 48 hours after uncomplicated vaginal delivery and four days after uncomplicated cesarean section. They were evaluated in hospital and followed up in the home by specially trained public health nurses who provided surveillence, support and education over a two to three day period. During the first year of the program 33% of all eligible patients availed themselves of this opportunity. Over 90% indicated that they were satisfied with the program and would consider using it again in in a future pregnancy. Although less than half of the physicians were in favour of the program at the start, over 70% were in favour at the end of the first year. There was no significant resulting morbidity in mothers or babies. A summary of the report is attached as Appendix 2.

In reviewing the current trends towards shorter stay and the St. Boniface experience, the committee agreed that the postpartum stay could safely be reduced throughout the province if the necessary backup services are made available.

RECOMMENDATION:

GIVEN PROPER BACKUP SERVICES THE IDEAL LENGTH OF STAY IN HOSPITAL THROUGHOUT MANITOBA FOLLOWING DELIVERY SHOULD BE AS FOLLOWS:

PRIMIGRAVIDA- UP TO 72 HOURS WITH 75% OF PATIENTS BEING DISCHARGED IN 48 HOURS.
MULTIPARA - 48 HOURS.
CESAREAN SECTION - 4 DAYS.
COMPLICATED VAGINAL DELIVERIES OR CESAREAN SECTION - DEPENDENT ON NATURE OF COMPLICATION.

4. Backup Services and Conditions Necessary for Expansion of the Postpartum Early Discharge Program

To identify what backup services and conditions would be necessary the committee reviewed the factors which currently seem to be preventing early discharge.

1. Lack of a modern comprehensive and properly coordinated postpartum public health nursing system has been the single largest deterrent to early discharge in postpartum patients in the past. An equally significant factor has been poor communication between the existing public health system and physicians and a lack of physicians awareness of the facilities that are available.
2. Patient expectations. Patient expectations are shaped by three major factors.
   - i) Tradition - patients perceive that four days is the required stay because it has always been so and this perception is reinforced by the conservative approach of most physicians.
   - ii) Physician advice - patients are heavily influenced by the opinion of their attending physician.
   - iii) Prenatal education classes - This is a powerful instrument in fashioning consumer expectations and demands and has not yet been used to its fullest. Patient expectations and demands have a significant impact on physician decision-making and behaviour.
3. Physician attitude- Physicians (obstetricians, family physicians and pediatricians) have, justifiably, been unwilling to discharge patients

into the community before the fourth postpartum day because of the perceived inadequacies of the public health nursing system in the past. There is therefore some continuing scepticism of the newer, properly designed follow-up programs, which have been introduced and are being proposed.

4. Out-of-town patients - Early discharge of out-of-town patients is currently not feasible because a) travel for prolonged distances so soon after delivery is not desirable and there may not be an appropriate public health follow-up service, b) there is no adequate hostel accommodation in Winnipeg. These patients often remain two or three days extra in hospital.
5. Delays in discharge of the baby - this is a major cause of delayed discharge and usually arises to some minor neonatal complication such as hyperbilirubinemia. However, in some cases there seems to be an undue reluctance of pediatricians to support the early discharge philosophy despite the provision of adequate ongoing infant surveillence.

RECOMMENDATIONS

1. POSTPARTUM EARLY DISCHARGE PROGRAMS MODELLED ON THE PILOT PROJECT AT ST. BONIFACE SHOULD BE SET UP TO SERVE THE WHOLE OF WINNIPEG AND EVENTUALLY THE WHOLE PROVINCE. ALTHOUGH THE PROGRAM MAY NOT BE REQUIRED OR DESIRED BY ALL IT SHOULD BE AVAILABLE TO ALL PATIENTS, WHO SHOULD BE SCREENED AS TO THEIR NEEDS ON ADMISSION TO THE UNIT AND REASSESSED PRIOR TO DISCHARGE.

2. PUBLIC HEALTH NURSES SHOULD HAVE SKILLS AND KNOWLEDGE UPGRADED AND UPDATED IN OBSTETRICS AND NEONATOLOGY FOR PARTICIPATION IN THIS PROGRAM; THEY SHOULD HAVE A CLOSE WORKING RELATIONSHIP WITH THE HOSPITAL(S) AND A PUBLIC HEALTH NURSE COORDINATOR SHOULD BE SITUATED IN EACH HOSPITAL.

3. A SYSTEM OF STANDARDIZED PERINATAL PATIENT EDUCATION MUST BE SET UP IN THE PROVINCE.

4. PHYSICIANS (OBSTETRICIANS, FAMILY PHYSICIANS AND PEDIATRICIANS) MUST BE EDUCATED ON THE SAFETY AND ADVANTAGES OF EARLY DISCHARGE AS PART OF A COORDINATED PROFESSIONAL EDUCATION PROGRAM.

5. HOSTEL ACCOMMODATIONS SHOULD BE PROVIDED AT THE TWO TERTIARY CARE HOSPITALS FOR POST PARTUM PATIENTS AS AN INSURED SERVICE.

   A) TO ALLOW EARLY DISCHARGE OF OUT-OF-TOWN PATIENTS WITH THEIR BABIES WITH VISITATION BY EARLY DISCHARGE NURSES WHERE THESE SERVICES ARE NOT AVAILABLE IN THE COMMUNITY.
   B) TO ALLOW DISCHARGE OF OUT-OF-TOWN MOTHERS WHOSE BABIES ARE DETAINED IN THE NURSERIES ALLOWING FREQUENT VISITING AND BONDING.

   CONSIDERATION SHOULD ALSO BE GIVEN TO THE NEED FOR PROVISION OF HOSTELS OR BOARDING HOUSE NETWORKS AS AN INSURED SERVICE IN ASSOCIATION WITH REGIONAL HOSPITALS.

NEONATOLOGY

Four areas of concern were identified in Neonatology.

- An insufficient number of neonatal intensive care beds for the province.
- A medical manpower shortage in the Intensive Care Nurseries.
- Inadequate follow-up of high risk neonates for long term sequelae.
- Insufficient provision for resuscitation and stabilization of the newborn in some units outside of the tertiary care centres.

1. Neonatal Intensive Care Beds

The number of neonates requiring intensive care in this province has increased over the past 10 years due to improvements in standards of care and new technology. Babies who were previously too ill or premature to live are now surviving, often remaining in the nursery for weeks or months before discharge. This increase in numbers has resulted in overcrowding and, on one or two occasions, out-of-province transfer.

The standard of the American College of Obstetricians and Gynecologists for the required number of I.C.N. beds is 1.7 to 2.0 per 1000 deliveries. With a delivery rate of approximately 18,000 per annum in Winnipeg's catchment area, including Northwest Ontario and Keewatin, We would therefore require 31 to 36 N.I.C.U. beds. We currently have only 22 N.I.C.U. beds housed in cramped and inadequate space. Our current capability is to ventilate 19 neonates increasing to 21 by March 1st, 1985. With the planned relocation of the N.I.C.U. at Children's Hospital over the next one or two years there will be a capacity to ventilate 18 neonates at Children's Hospital (originally projected for October 1985 this will now not materilize by that date). With the existing capability of ventilating 12 neonates at St. Boniface N.I.C.U. there will therefore be a physical facility staffed and equipped to provide the highest quality tertiary care to 30 neonates. This increase will be almost sufficient to meet the present needs in Winnipeg and its catchment area. These increased resources are urgently needed to prevent long term morbidity of high risk neonates.

RECOMMENDATION

THE PROPOSED INCREASE IN NEONATAL INTENSIVE CARE BEDS SHOULD PROCEED AS A MATTER OF URGENCY TO ACHIEVE A MINIMUM OF 31 BETWEEN THE TWO HIGH RISK CENTRES, THIS NUMBER TO BE ADJUSTED FROM TIME TO TIME AS BIRTH RATES FLUCTUATE TO MAINTAIN THE MINIMUM REQUIRED NUMBER.

2. Medical Manpower

Because of increasing patient volume in the Neonatal Intensive Care Units and a reduction in residents/fellows available to care for these patients a manpower crisis has arisen over the past two or three years. This has been solved temporarily by employing physicians as house officers on a casual basis at considerable cost. A proposal has been developed by the Section of Neonatology and the Department of Nursing at the University of Manitoba for a training program for neonatal nurse clinicians. These nurse specialists are seen as being cost effective in replacing residents and house officers, working in the nursery by protocol under the supervision of a neonatologist. A copy of the proposal developed by Neonatology and Nursing is appended as Appendix 3. The committee has reviewed this proposal and regards it as a viable long term solution to the manpower problem in Intensive Care Nurseries providing competent management of the neonate by expert personnel at reasonable cost.

RECOMMENDATION

A PROGRAM SHOULD BE ESTABLISHED IN MANITOBA IMMEDIATELY TO EDUCATE NURSES TO ASSUME THE ROLE OF NEONATAL NURSE CLINICIAN IN ORDER TO MEET THE URGENT MANPOWER NEEDS OF THE TWO TERTIARY CARE CENTRES.

3. Follow-up of High Risk Neonates

The importance of systematic follow-up of high risk neonates discharged from the Neonatal Intensive Care Units is generally recognized and there are few high risk obstetric programs in Canada which do not have such follow-up programs. It was generally agreed by the committee that provision of adequate follow-up is of vital importance in providing feedback to obstetrician and neonatologist concerning the effectiveness and appropriateness of interventions and management. The committee agreed that a significant saving should be possible if we can identify which treatments provide the healthiest babies, whether particular interventions might be causing handicap and which babies require intervention in infancy and childhood to help them become more productive members of society. This can only be done by systematic follow-up and formal assessment through a structured program. Only the Health Sciences Centre in Manitoba has such a program. It was agreed by the committee that it is unacceptable and probably unethical to operate a high risk perinatology unit without such follow-up. A High Risk Follow-up Program should have two objectives:

a) To develop an outcome assessment of these high risk infants for feedback to obstetricians and neonatologists.
b) To implement and evaluate interventions in the neonatal period, infancy and childhood to facilitate the optimal neuromotor development of the high risk infant.

RECOMMENDATIONS:

1. THE EXISTING MECHANISM FOR THE IDENTIFICATION OF THE HIGH RISK INFANT IN THE NEONATAL PERIOD SHOULD BE EXPANDED AND IMPLEMENTED AT BOTH TERTIARY CARE INSTITUTIONS WITH A SYSTEM OF FORMAL COMMUNICATION OF INFORMATION TO THE PHYSICIAN AND PUBLIC HEALTH NURSE IN THE COMMUNITY.

2. A FOLLOW-UP PROGRAM MUST BE AVAILABLE FOR EVALUATION OF NEURODEVELOPMENTAL OUTCOME OF HIGH RISK INFANTS DISCHARGED FROM BOTH NEONATAL INTENSIVE CARE UNITS TO ASSESS PROVINCIALLY THE EFFICACY OF INTERVENTION AND THERAPY IN THE ANTEPARTUM, INTRAPARTUM AND NEONATAL PERIODS.

3. PROVISION MUST BE MADE TO INCLUDE IN THESE FOLLOW-UP PROGRAMS SERVICES AND THERAPIES REQUIRED BY HIGH RISK INFANTS TO ALLOW THEM TO DEVELOP TO THEIR FULL POTENTIAL AS INDIVIDUALS.

4. Provision for Resuscitation and Stabilization of the Newborn Outside the Tertiary Care Centres

The committee reviewed the requirements for infant resuscitation and stabilization on obstetric units. There was unanimous agreement that centres offering obstetric services must have personnel available at the time of delivery competent to adequately resuscitate the depressed newborn and stabilize the sick or premature neonate prior to transfer to a Neonatal Intensive Care unit. The solutions for rural and urban areas may well be different because of the differences in obstetric volumes going through these units.

In community hospitals in Winnipeg a 24 hour anaesthesia service would be the ideal and would provide both infant resuscitation/ stabilization and anaesthesia services in the event of obstetric emergencies. Such 24 hour anaesthesia availability would require a delivery rate in excess of 1500 per year to justify its existance. To make such a proposition cost effective it will be necessary to establish an obstetric anaesthesia retention fee in all such units.

In rural hospitals it is unlikely that a delivery rate sufficient to justify in-house anaesthesia will ever be achieved and some other mechanism must be sought. Resuscitation and stabilization skills could, however, be provided by any physician, nurse or respiratory technologist, provided there are properly structured educational programs in place to develop and maintain these skills. Such programs would ideally be a part of the overall educational program of a provincial Perinatology Program.

RECOMMENDATIONS:

1. IN ALL CASES WHERE EARLY IDENTIFICATION OF PATIENTS AT INCREASED FETAL OR NEONATAL RISK IS POSSIBLE THESE PATIENTS SHOULD BE TRANSFERRED TO A HIGH RISK CENTRE FOR DELIVERY.

2. ALL HOSPITALS OFFERING OBSTETRIC SERVICES SHOULD HAVE IN-HOUSE SKILLS FOR INFANT RESUSCITATION AND STABILIZATION AT THE TIME OF DELIVERY.

3. SUCH SKILLS SHOULD BE PROVIDED EITHER THROUGH THE AVAILABILITY OF A 24 HOUR ANAESTHESIA SERVICE (WITH AN APPROPRIATE RETENTION FEE) OR APPROPRIATE TRAINING SHOULD BE PROVIDED TO EQUIP DESIGNATED PHYSICIANS, NURSES OR RESPIRATORY TECHNOLOGISTS TO PERFORM THESE FUNCTIONS.

4. THE CURRENT NEONATAL TRANSPORT SYSTEM SHOULD BE EXTENDED TO SERVE THE WHOLE OF THE PROVINCE OF MANITOBA.

DEFINITION OF APPROPRIATE LEVELS OF CARE IN UNITS OUTSIDE OF WINNIPEG

The committee expressed concern about the failure of some of the larger centres outside Winnipeg to refer high risk mothers and neonates to the two major tertiary care units. The committee believes that this tendency to look afer tertiary care problems in inadequately equipped and staffed facilities is to be discouraged and has partly resulted from M.H.S.C.'s failure to accept the guidelines produced by the College of Physicians and Surgeons on the definition of primary, secondary and tertiary care institutions. This document defines levels of service and the staff and resources necessary to provide adequate service for the various levels of care. A copy of these recommendations is attached as Appendix 4.

RECOMMENDATION:

THE COMMITTEE RECOMMENDS THAT M.H.S.C. REVIEW AND ACCEPT THE DOCUMENT "RECOMMENDED STANDARDS FOR MATERNAL AND NEWBORN CARE" AND THAT STEPS BE TAKEN TO ENSURE THAT THE LEVEL OF CARE AND FACILITIES OFFERING TERTIARY CARE SERVICE CONFORM TO THESE STANDARDS.

GYNECOLOGY

The committee reviewed the range of gynecology procedures and diagnoses commonly encountered in this province, with a view to making recommendations on a) criteria concerning the suitability for N.F.A. vs. in-patient management, b) optimal length of stay in hospital and c) improving utilization and efficiency of current gynecology N.F.A. programs.

Appendix 5 lists these diagnoses or procedures with:-

(i) The committee's opinion on suitability for N.F.A. vs. in-patient management.

(ii) The average length of stay for admitted cases in Manitoba for 1983.

(iii) The average length of stay from Kaiser-Permenante (Oregon) statistics for 1983/84.

(iv) A suggested appropriate length of stay for admitted patients for each diagnosis/condition in this community. (column 2)

The statistics in this table are open to many criticisms and interpretations as we are not sure what criteria govern the Kaiser stats; also, the Manitoba average length of stay applies only to that proportion of patients who had surgery on an inpatient basis and includes complicated and uncomplicated cases.

However, the figures, such as they are, suggest that a number of conditions, considered suitable by the committee for day surgery are frequently being done as inpatient procedures (eg. D&C following spontaneous abortion, laparoscopy, D&C). Also some average lengths of inpatient stay exceed the figures recommended by the subcommittee and/or the Kaiser figures (eg. abdominal and vaginal hysterectomies).

It must be emphasized that the opinions given in this table concerning optimal length of stay are generalizations and individual factors in a given patient's condition and situation may significantly alter the length of stay or the decision as to whether or not to admit or manage a patient on an N.F.A. basis. The committee therefore regards this appendix as a working document from which they have derived their observations and recommendations.

The committee identified a number of factors which appear to promote the inappropriate use of hospital beds for minor gynecology procedures and which delay the discharge of in-hospital patients.

1. Inadequate facilities and funding for N.F.A. programs - N.F.A. programs in some health care institutions tend to be regarded as an "add-on" or fringe benefit to be fitted in among other hospital programs if possible. In at least one major hospital recovery beds are not dedicated to N.F.A. and are frequently occupied by off-service patients. This results in frequent cancellation of the N.F.A. slate with an increasing reluctance of medical staff to use the N.F.A. facilities. Until ambulatory and N.F.A. programs are elevated to an appropriate level of priority in the plans of hospital administrations, it is unlikely that much headway will be made in promoting expansion of N.F.A. surgery.

2. The unavailability of N.F.A. facilities to deal with minor emergency gynecology procedures, such as D&C for incomplete abortion or marsupulization of a Bartholin's abscess.

3. Lack of suitable lodgings for out-of-town patients. This results in patients, who would otherwise be suitable for ambulatory management, being admitted for "boarding" purposes.

4. Less than optimal pre-operative counselling, patient compliance, workup and documentation.

5. Absence of a well coordinated Early Discharge Program for patients following major gynecology surgery.

6. Uneven application of admission and discharge policies by hospital committees with this responsbility.

RECOMMENDATIONS:

1. ADEQUATE FUNDING AND FACILITIES SHOULD BE PROVIDED FOR N.F.A. PROGRAMS WITH SEPARATE AND DEDICATED RECOVERY AREAS AND BEDS.

2. N.F.A. PROGRAMS SHOULD PROVIDE FOR EMERGENCY MINOR GYNECOLOGY PROCEDURES.

3. N.F.A. UNITS OR SURGICENTRES SHOULD HAVE READY ACCESS TO FULL HOSPITAL BACKUP FACILITIES.

4. HOSTELS SHOULD BE PROVIDED AT THE TWO TEACHING HOSPITALS FOR THE USE OF DISPLACED PATIENTS.

5. STEPS SHOULD BE TAKEN TO STANDARIZE AND ENSURE COMPLETENESS OF PRE-OPERATIVE WORKUP FOR N.F.A. PATIENTS TO AVOID UNNECESSARY CANCELLATION. IT IS RECOMMENDED THAT A STANDARDIZED N.F.A. FORM OR FORMAT BE DEVELOPED WITH A WRITTEN INSTRUCTION SHEET FOR USE THROUGHOUT THE PROVINCE.

6. AN ADEQUATE NURSING EDUCATION PROGRAM SHOULD BE PROVIDED IN THE HOSPITAL PRIOR TO DISCHARGE AND A PUBLIC HEALTH NURSE FOLLOW-UP PROGRAM SHOULD BE DEVELOPED TO PROVIDE HOME VISITS FOR SELECTED POST-OPERATIVE EARLY DISCHARGE PATIENTS.

7. HOSPITAL OR DEPARTMENTAL ADMISSION AND DISCHARGE COMMITTEES SHOULD ACTIVELY MONITOR THE INDICATIONS FOR ADMISSION TO ACUTE CARE BEDS AS WELL AS LENGTH OF STAY AND SHOULD IMPLEMENT ADMISSION AND DISCHARGE POLICIES WITH CROSS INSTITUTIONAL COMPARISONS. THIS ACTIVITY SHOULD BE THE RESPONSIBILITY OF THE MEDICAL STAFF ASSOCIATION AT EACH HOSPITAL.

8. FUNDING SHOULD BE PROVIDED FOR SPECIALTY AMBULATORY PROGRAMS SUCH AS CERVICAL COLPOSCOPY AND CRYOTHERAPY, OVUM PICK-UP AND EMBRYO TRANSFER AND LASER SURGERY.

OBSTETRIC BED DISTRIBUTION AND UTILIZATION IN WINNIPEG

One of the terms of reference of the Health Services Review Committee identified in the Minister's speech of June 1984, is "the identification of major cost centres and exploration of the possibility of consolidation". The committee therefore considered this issue in some depth in its meetings in November and December and made a number of observations and recommendations.

Financial information provided by M.H.S.C. for 1982/83 indicates that the cost of a delivery in a given unit decreases with increasing volume of deliveries.

TABLE I
1982 - 1983

	DELIVERIES	COST/DELIVERY
HEALTH SCIENCES	3150	$ 1283
ST. BONIFACE	3507	1173
GRACE	1371	1303
VICTORIA	1055	1238
MISERICORDIA	779	1572
CONCORDIA	448	1647
SEVEN OAKS	373	2181

In spite of the immense cost associated with increased acuity of maternal and neonatal care at Health Sciences Centre and St. Boniface General Hospital the cost per delivery in the high risk centres is less than almost all of the community hospitals.

On the basis of this information the obstetric units in two community hospitals were closed in 1983 in an attempt to improve overall cost effectiveness. The closure of both units effected a saving of $1,600,000/annum in operating budgets. Of this, $800,000/annum was reassigned to Health Sciences Centre and St. Boniface General Hospital to meet the increased obstetric volume at these centres. The balance $800,000/annum represented a savings and was reallocated to preventative programs. It is interesting to note that, in addition to being able to save this amount, the cost for delivery remained the same in the remaining hospitals over the two year period despite inflation. (Table II)

TABLE II

	DELIVERIES*	TOTAL COST	COST/ DELIVERY
1982 - 83	9,862	$12,473,810	$ 1,264.83
1983 - 84	10,819	$13,711,410	$ 1,267.34

* Deliveries in all Winnipeg Hospitals with the exception of Seven Oaks and Concordia.

The costs of delivery in the remaining units during 1983/84 are shown in Table III.

TABLE III

1983 - 1984

	DELIVERY	COST/DELIVERY
HEALTH SCIENCES CENTRE	3638	1309
ST. BONIFACE HOSPITAL	3309	1481
GRACE HOSPITAL	1381	1406
VICTORIA HOSPITAL	1497	968
MISERICORDIA	994	1325

All of these figures would tend to support the contention that units with higher delivery rates run more cost effectively (due consideration being given to the increased cost of high risk mothers and babies at Health Sciences Centre and St. Boniface General Hospital). This can be readily understood when it is recognized that approximately .80 out of every dollar spent in the budget of an obstetric unit is spent on salaries, most of these nursing. If nursing staff are underemployed and if expensive equipment is underutilized due to low work volume, then costs will inevitably be higher. Economy of scale only becomes apparent when deliveries exceed 1000/annum.

With this background the committee looked at the current distribution of deliveries in the city of Winnipeg (1984) with a view to exploring whether additional savings could be effected by further consolidation.

Table IV shows the distribution of deliveries by hospital for 1985 (projected) on the basis of the first seven months of the fiscal year.

TABLE IV

	No.Deliveries		
HEALTH SCIENCES CENTRE	3,747		
ST. BONIFACE HOSPITAL	3,862	Total, High Risk Centres - 7,609	
GRACE HOSPITAL	1,449		
VICTORIA HOSPITAL	1,471	Total, Community Hospitals	
MISERICORDIA HOSPITAL	857		- 3,777
		WINNIPEG TOTAL	11,386

Table V shows the maximum obstetric capacity of each unit as estimated by the Heads of Obstetrics and Gynecology of each hospital with existing facilities.

TABLE V

	No.Deliveries		
HEALTH SCIENCES CENTRE	3,800		
ST. BONIFACE HOSPITAL	4,000	Total, High Risk Centres - 7,800	
GRACE HOSPITAL	1,800		
VICTORIA HOSPITAL	1,800	Total,Community Hospital- 5,400	
MISERICORDIA HOSPITAL	1,800		
		TOTAL	13,200

These figures suggest that deliveries in Winnipeg could be handled in fewer hospitals. If one community obstetric unit capable of delivering

1800 deliveries per year were eliminated, this would result in a delivery capability of 11,400 for the whole city, which equals almost exactly the birth rate in 1984.

However, the committee identified a number of practical problems which would prevent the implementation of any such closure in the immediate future. These were as follows:-

1. The number of obstetric beds in the city would be so tightly matched to the number of deliveries that there would be an insufficient amount of slack in the system to accommodate high birth rate peaks (which occur several times in each year), industrial action resulting in strikes, outbreaks of infection in nurseries or obstetric units, etc.
2. While the number of delivery, recovery, postpartum and nursing beds in the city appear to be sufficient for a delivery rate of 11 or 12 thousand, (using the standards of the American College of Obstetrics and Gynecology Appendix 5. The number of labour beds appears to be inadequate. Although we seem to have handled over 11,000 deliveries in the past year without difficulty in these labour beds, standards indicate that we should only be delivering 9,600 per annum with our present numbers. If the number of units is reduced, this could become a critical issue and this will need to be studied and corrected before any changes are made.
3. When a hospital department closes there is no guarantee that the patients or their physicians will use one of the remaining community hospitals. Indeed, if (for example) the Misericordia were to discontinue obstetrics, existing patterns of practice and referral would indicate that most of the deliveries would transfer to St. Boniface Hospital. St. Boniface could not cope with such an influx at this time.
4. Anaesthesia services at remaining hospitals would have to be adequate to safely provide service for the increased number of deliveries. This issue is so important that the committee believes that an adequate anaesthesia services should be ensured in the remaining hospitals before any closure. This would be best done by the provision of a retention fee for anaesthetists in any hospital withing the city offering obstetric services. Considering the present shortage of anaesthetists in some community hospitals, it would also be prudent to ascertain the availability of anaesthesia staff prior to implementing any redistribution.

5. When an obstetrician is required to move his obstetric practice to another hospital, he will also require gynecology operating privileges in that hospital. In at least two hospitals that will be required to accept patients and physicians there is already inadequate gynecology operating time to accommodate the needs of existing staff. This issue would have to be resolved prior to any closure to the satisfaction of the physician and his patient. The alternative of requiring that the obstetrician do his gynecology in a third hospital is unacceptable because of the negative impact this would have on the quality of obstetric patient care due to physician unavailability.

The committee therefore believes that while there is a definite place for further consolidation of obstetric services, this must be done with great care and only after the above concerns have been satisfactorialy addressed.

For completeness and, to ensure that no option is overlooked, the committee considered in detail four alternative proposals for reallocation of obstetric beds within the city. In the interests of keeping this report as brief as possible, these discussions have been summarized in Appendix 5 and are attached to the report. In summary, it can be said that the committee believes that two well equipped obstetric units, each with separate high and low risk units within the same facility, would best and most cost effectively serve the needs of the city of Winnipeg as was first proposed in the "Peddle Report". Although, we believe that this is not practical at this time (as it would require an expensive new building program at both tertiary care hospitals), it is a goal which government and the hospitals should work towards over the next 10 years. The most appropriate solution for implementation in the short term is the closure of an obstetrical unit in one of the community hospitals; however, this should only be done after the planned expansion of the perinatal units at the Health Sciences Centre and St. Boniface and in close consultation with an ad hoc committee representing the professions involved to avoid the potential problems previously identified.

The committee did not feel in a position, at this time, to indicate which two community hospitals should continue to offer obstetric services. However, they felt that this decision should be made at the appropriate time by government, in consultation with the professions using the following general criteria.

1. Number of deliveries.
2. Suitabiltiy of the physical plant and ability to accommodate up to 2000 deliveries per year.
3. Ability, availabiltiy and willingness of an adequate anaesthesia staff to provide 24 hour anaesthesia and infant resuscitation services.
4. Geographic accessibility to patients throughout Winnipeg.
5. Ability to provide a full range of services in Obstetrics and Gynecology.
6. Adequate gynecology operating time and facilities to support the increased obstetrics and gynecology staff.
7. An evaluation of potential referral patterns from any unit proposed for closure with an assessment of cupability of likely receiving hospital (s).

RECOMMENDATIONS:

1. FIRST PRIORITY SHOULD BE GIVEN TO UPGRADING AND EXPANSION OF THE PERINATAL UNITS AT HEALTH SCIENCES CENTRE AND ST. BONIFACE TO ACCOMMODATE UP TO 4500 DELIVERIES PER YEAR AT EACH UNIT WITH PROVISION FOR BOTH HIGH RISK AND FAMILY CENTERED CARE.

2. FOLLOWING COMPLETION OF EXPANSION AT THE TERTIARY CARE CENTRES, CONSIDERATION SHOULD BE GIVEN TO CLOSURE OF ONE OBSTETRIC UNIT IN A COMMUNITY HOSPITAL; THE OBSTETRIC NEEDS OF THE CITY WOULD THEN BE SERVED BY TWO COMBINED HIGH RISK/LOW RISK CENTRES AND TWO COMMUNITY HOSPITAL OBSTETRIC UNITS.

3. THE SELECTION OF COMMUNITY HOSPITALS TO CONTINUE OBSTETRIC SERVICES SHOULD BE BASED ON THE CRITERIA SUGGESTED BY THE COMMITTEE AND THIS MUST BE DONE IN CONSULTATION WITH AN AD HOC COMMITTEE REPRESENTING THE PROFESSIONS AFFECTED.

4. GOVERNMENT AND THE HOSPITALS SHOULD ADOPT, AS A LONGTERM GOAL, THE IDEAL OF TWO OBSTETRIC UNITS TO SERVE THE CITY OF WINNIPEG, EACH WITH SEPARATE LOW RISK AND HIGH RISK AREAS BUT ALL UNDER ONE ROOF AND ON ONE FLOOR.

OBSTETRIC BED DISTRIBUTION AND UTILIZATION IN MANITOBA OUTSIDE WINNIPEG

The committee reviewed the number, distribution and delivery rates of rural hospitals in Manitoba offering obstetric services. It is clear that a large number of hospitals deliver a very small number of babies per annum. For example, Wawanesa, Glenboro, Boissevain and Baldur are all hospitals with 15 deliveries or less per year, situated within 30 minutes driving distance of each other. The committee discussed the problems of continuing competence, expense and lack of availability of anaesthesia and resuscitation services associated with these low delivery rates. There is general agreement that consolidation of obstetric services in one hospital in an area such as this would improve obstetric standards and the back-up services which can be made available. However, there is some doubt as to whether this would result in any savings as labour and delivery units are staffed by the general hospital staff. Other factors come into play in rural areas, such as the role of the local hospital as a source of employment and civic pride, the impact of obstetrics in retaining the interest (and indeed services) of the local doctor and the wish of patients to be delivered in their own home town.

Following extensive discussion of this issue the committee concluded that change would be more easily and appropriately effected by education than by legislation. It would be wrong to arbitrarily and summarily close units. Rather a well coordinated educational campaign should be launched to educate health care professionals and patients in the rural areas covering recent advances and current obstetric practice, consulting services which are available and the factors which contribute to better perinatal care and reduction of morbidity and mortality. It can then be anticipated, as has been seen in Winnipeg, that both physician and patient will make an informed decision to practice and deliver in hospitals with an increased obstetric volume and consequently better back-up facilities.

Such a proposal has been jointly developed by the College of Physicians and Surgeons of Manitoba and the Manitoba Association of Registered Nurses. The proposal has the support of the Maternal and Child Health Advisory Committee as a component of an overall provincial perinatal program. This has been presented to M.H.S.C. but has not been accepted. The proposal is attached to this report as Appendix B.

RECOMMENDATIONS:

1. THE COMMITTEE RECOMMENDS THAT M.H.S.C. AGAIN REVIEW THE PROPOSED MANITOBA PERINATAL EDUCATION PROGRAM AS A MATTER OF PRIORITY. THIS SHOULD BE DONE WITH A VIEW TO USING THIS AS A MECHANISM TO IMPROVE OBSTETRIC AND NEONATAL CARE IN THE RURAL AREAS AND TO FACILITATE DESIRABLE TRENDS, SUCH AS CONSOLIDATION AND REGIONALIZATION AS A VOLUNTARY, EVOLUTIONARY PROCESS. THIS PROGRAM SHOULD BE PART OF AN OVERALL PROVINCIAL PERINATAL PROGRAM.

2. IN ORDER TO DEVELOP AND MAINTAIN A VIABLE PROFESSIONAL EDUCATIONAL PROGRAM WITH SIGNIFICANT IMPACT THE COMMITTEE RECOMMENDS THE INCORPORATION OF THE RECOMMENDATIONS ON PAGE 33.

THE EXPANDED ROLE OF THE NURSE IN REPRODUCTIVE HEALTH CARE

Presentations were made to the committee by Mrs. Edith Parker, Frank Manning and Dr. Molly Seshia urging the development of nurse specialists in a number of areas of Reproductive Health Care as follows:

1. As nurse midwife in the care of low risk obstetric patients in antepartum, intrapartum and postpartum periods.
2. As nurse clinicians providing primary care in the Neonatal Intensive Care Nurseries under the direction of neonatologists.
3. In the expanded use of home care programs for
   i. Early discharge following uncomplicated delivery and cesarean section.
   ii. Home surveillence of patients at increased risk of antepartum complications.
   iii. Early discharge of patients following gynecologic surgery.
   iv. Pre-operative evaluation and education prior to N.F.A. surgery.
4. In screening patients at increased obstetric risk in existing Fetal Assessment Units and in an expanded provincial antepartum outreach program involving the use of real time ultrasound.
5. In screening for gynecologic disease in the general population (such as the use of ultrasound screening of the general population for very early ovarian cancer).
6. In specialty areas such as infertility clinics where counselling,management by protocol and ongoing monitoring is possible under physician supervision.

Many of these proposed roles have already been identified in other parts of this report and are discussed in more detail in the discussion paper prepared by Mrs. Parker and Dr. Manning on behalf of the committee. This has been accepted by the committee and is attached as Appendix 6.

This committee agrees that it is reasonable, in these times of fiscal restraint, to reopen the question of whether certain functions need to be performed by physicians, or whether they can be as effectively and less expensively performed by delegation to adequately trained and experienced nurses specialists. Because of the time constraints imposed on this committee to complete their task, we do not feel that it is possible to do justice to this topic in the time available. We support the recommendation that an ad hoc committee be formed to explore the area in depth and make recommendations

RECOMMENDATIONS:

1. AN AD HOC TASK FORCE SHOULD BE SET UP TO STUDY AND MAKE RECOMMENDATIONS ON THE ISSUE OF THE EXPANSION OF THE ROLE OF THE NURSE IN REPRODUCTIVE HEALTH CARE WITH PARTICULAR REFERENCE TO FETAL ASSESSMENT, NEONATAL INTENSIVE CARE, ANTEPARTUM CARE AND SURVEILLENCE, NURSE MIDWIFERY, SCREENING FOR GYNECOLOGIC DISEASE AND INVOLVEMENT IN SPECIALTY AREAS SUCH AS INFERTILITY.

2. NOTWITHSTANDING THE PRECEEDING RECOMMENDATION, THE COMMITTEE RECOMMENDS THAT, BECAUSE OF THE ACUTE MANPOWER SHORTAGE IN THE NEONATAL INTENSIVE CARE NURSERIES, A NEONATAL NURSE CLINICIAN TRAINING PROGRAM BE SET UP IMMEDIATELY AS ALREADY RECOMMENDED IN THE NEONATOLOGY SECTION.

PROFESSIONAL AND PATIENT EDUCATION

The committee has stressed throughout this report that one of the most effective mechanisms in moving the profession and the community towards more effective use of the health care resources is a well coordinated education program for health care providers and consumers.

Education through the C.M.E. Program of the College of Physicians and Surgeons has brought about major changes in patterns of obstetric practice and referral over the past 10 years. There has been an increase in the referral of high risk cases from community hospitals and rural areas to the tertiary centres with a demonstrated preference by obstetricians for delivery in hospitals with superior backup services.

Similarly, patient education through a network of prenatal classes, literature and the media has gone a long way to making patients aware of the importance of prenatal care, diet, the effects of smoking and alcohol, the process of labour and the potential risks to mother and baby. This has resulted in a more sophisticated population, many patients holding strong views on issues such as non-intervention obstetrics, family centered care and the availability of neonatal and anaesthesia services.

However, the committee believes that education for both groups could be greatly improved and could be more effectively used for the systematic improvement of perinatal care. The information provided at prenatal classes is sometimes outdated, inaccurate and inconsistent from one class to another. Physician and nursing education in some rural areas is more available than in others. The defects in the present system are attested to by the persisting high rate of cesarean section for conditions such as previous cesarean section; the resistance offered by some to properly designed early postpartum discharge programs; resistance of some rural communities to any suggestion of consolidation or regionalization, etc.

C.M.E. FOR HEALTH CARE PROFESSIONALS

RECOMMENDATION

M.H.S.C. SHOULD AGAIN REVIEW THE PROPOSED MANITOBA PERINATAL EDUCATION PROGRAM (APPENDIX 7) AS A MATTER OF PRIORITY, RECOGNIZING THIS TO BE A MECHANISM FOR IMPROVING THE STANDARDS AND COST EFFECTIVENESS OF OBSTETRIC AND NEONATAL CARE IN RURAL AND URBAN AREAS.

THIS PROGRAM:
- SHOULD BE PART OF AN OVERALL PROVINCIAL PERINATAL PROGRAM.
- SHOULD INCLUDE BOTH PHYSICIANS AND NURSES.
- SHOULD BE PROPERLY FUNDED WITH:
  1) AN ADEQUATE SESSIONAL FEE TO COMPENSATE PHYSICIANS (UNIVERSITY OR PRIVATE PRACTICE) FOR TIME LOST IN PRACTICE WHEN INVOLVED IN EDUCATIONAL ACTIVITIES.
  2) A SALARY FOR TWO OR THREE CORE PEOPLE WITH PROTECTED TIME TO ADEQUATELY PLAN, COORDINATE AND DELIVER SUCH EDUCATION.
- SHOULD MAKE USE OF TIME SAVING AND COST EFFECTIVE TEACHING METHODS SUCH AS TELECONFERENCING, VIDEO CASSETTE LIBRARY AND INCORPORATION OF PERINATAL EDUCATION IN MEETINGS OF THE COLLEGE OF FAMILY PHYSICIANS AND DISTRICT MEETINGS OF THE COLLEGE OF PHYSICIANS AND SURGEONS AND OF THE M.M.A.
- SHOULD INCORPORATE EXISTING EDUCATIONAL ACTIVITIES SUCH AS FETAL ASSESSMENT OUTREACH VISITS.
- SHOULD HAVE FINANCIAL RESOURCES IDENTIFIED FOR ITS SUPPORT.

This approach to the continuing professional education of physicians and nurses is essential to ensure high standards of patient care, to ensure efficient utilization of services and resources and to ensure that health care professionals throughout the province are kept abreast of the changing philosophies of obstetric management.

Examples of issues which might be emphasized in such programs are the availability and proper utilization of early postpartum discharge programs; the availability and indications for the Antepartum Surveillence Program; the place for trial of labour in previous cesarean sections; the principles and techniques of neonatal resuscitation and stabilization.

PERINATAL EDUCATION FOR PATIENTS

Patient perinatal education is currently provided in the form of structured classes, more informally in small group sessions or on a one-to-one basis as follows:

STRUCTURED:

- Prenatal classes in the community or in association with hospital departments.
- Postnatal classes on the wards.
- Viewing of close curcuit TV, video tapes and films on the postpartum wards.
- Literature provided by doctor's offices, at Prenatal Classes and on postpartum wards.

UNSTRUCTURED:

One-on-one nurse/patient teaching:

- In clinics and doctor's offices.
- On the high risk prenatal unit.
- On the postpartum wards and nursery.
- In the home in Early Discharge and Antepartum Surveillence Programs.
- In Antepartum Outreach visits to rural areas.

Education in all these forms constitutes a powerful tool for effecting change in patient expectations and physician behaviour as well as improving perinatal outcome and efficient use of resources. For example, the education of patients in the advantages of trial of labour for cesarean section could result in a reduction of cesarean section rates with great savings. It would also prepare a patient for early return to the family unit following either cesarean section or vaginal delivery. Patient education in early labour and the proper timing of admission to the obstetric unit could reduce the incidence of intervention and associated complications and expense.

RECOMMENDATIONS:

1. THE CONTENT OF PRENATAL EDUCATION CLASSES SHOULD BE STANDARDIZED.

2. EDUCATORS SHOULD BE TRAINED AND LICENSED.

3. EDUCATION SHOULD EXTEND THROUGH THE PRENATAL, PERINATAL AND POSTNATAL PERIODS, EXTENDING INTO THE ELEVENTH MONTH.

4. WHERE IT IS PRACTICAL, AN ATTEMPT SHOULD BE MADE TO HAVE THE SAME INSTRUCTOR REMAIN WITH THE PATIENT THROUGHOUT.

5. THE GOAL MUST BE TO ENROLL ALL PATIENTS, BOTH PRIMIGRAVIDA AND MULTIPARA, AS STANDARDS CHANGE AND PATIENTS CIRCUMSTANCES CHANGE FROM PREGNANCY TO PREGNANCY.

6. CHILD SUPPORT SHOULD BEGIN WITH THE PATIENT'S FIRST PRENATAL VISIT AND/OR PRENATAL CLASS.

7. DIABETES EDUCATION PROGRAMS SHOULD BE AVAILABLE AND FREELY ACCESSABLE TO ALL WOMEN, PREGNANT AND NON-PREGNANT, AT BOTH TERTIARY CARE CENTRES AND IN REGIONAL CENTRES.

8. A STEERING GROUP SHOULD BE ESTABLISHED WITH MEDICAL AND NURSING REPRESENTATION TO SET UP A STANDARDIZED, STRUCTURED AND UNIFORM APPROACH TO PATIENT PERINATAL EDUCATION. THE GROUP WOULD HAVE RESPONSIBILITY FOR SETTING UP GUIDELINES, FOR INITIATING, COORDINATING AND MONITORING THE PROGRAM, AND FOR ENSURING THE PROVISION OF REGULAR INSERVICE AND UPDATING OF PRENATAL CLASS INSTRUCTORS IN OBSTETRICS AND NEONATOLOGY. THIS STEERING GROUP MIGHT FUNCTION AS A SUBCOMMITTEE OF THE PROVINCIAL PERINATAL PROGRAM STEERING COMMITTEE RECOMMENDED ELSEWHERE.

COORDINATION OF DELIVERY OF REPRODUCTIVE HEALTH CARE IN THE PROVINCE

The committee spent some time considering the existing mechanism for coordination and planning of reproductive health care in the province. Members expressed some concern regarding the number of perinatal committees which appear to function in an isolated fashion with little attempt at communication or collaboration. There are currently five committees, namely, the University Perinatology Committee, the Maternal and Child Health Advisory Committee, the Liaison Committee of the two tertiary care hospitals which meets intermittently, the Perinatal and Maternal Welfare Committee of the College of Physicians and Surgeons; and now the Obstetric Subcommittee of the Health Services Review Committee. It is not clear to whom some of these committees report and terms of reference are often vague. The committee believes that there is a need to consolidate the committee structure associated with planning and delivery of reproductive care in such a way that the flexibility and effectiveness of existing small committees is retained, while ensuring better communication and a coordinated approach.

RECOMMENDATION:

THE PRESENT PLETHORA OF COMMITTEES SURROUNDING PERINATOLOGY SHOULD BE REVIEWED AND THE SPECIFIC MANDATE AND TERMS OF REFERENCE OF EACH COMMITTEE MUST BE DEFINED. IT IS PROPOSED THAT ONE STEERING COMMITTEE BE ESTABLISHED TO OVERSEE A PROVINCIAL PERINATAL PROGRAM WITH SUBCOMMITTEES TO HANDLE SPECIFIC TASKS, EG. PROFESSIONAL EDUCATION, PATIENT EDUCATION, LIAISON BETWEEN TERTIARY CARE HOSPITALS, NEONATAL TRANSPORT, ETC. THE CHAIRMAN OF THESE SUBCOMMITTEES WOULD SIT ON THE STEERING COMMITTEE. THE CHAIRMAN, OR CO-CHAIRMEN, (OBSTETRICS AND NEONATOLOGY) OF THE STEERING COMMITTEE MAY EITHER HAVE A ROLE IN DIRECTING THE PROVINCIAL PERINATOLOGY PROGRAM, OR MAY FUNCTION AS ADVISOR AND COMMITTEE SPOKESMAN ON REPRODUCTIVE HEALTH CARE TO GOVERNMENT AND THE HEALTH SERVICES COMMISSION

SUMMARY OF RECOMMENDATIONS

ANTEPARTUM BED UTILIZATION

1. PHYSICIANS SHOULD BE ENCOURAGED TO MANAGE AS MANY ANTEPARTUM PROBLEMS AS POSSIBLE ON AN AMBULATORY BASIS WHERE THIS CAN BE DONE WITH SAFETY USING THE SERVICES IDENTIFIED IN THE FOLLOWING RECOMMENDATIONS.

2. THE COMMUNITY BASED HIGH RISK ANTEPARTUM HOME CARE PROGRAM CURRENTLY OPERATING AT ST. BONIFACE, (OFFERING FORMAL VISITING AND MONITORING BY APPROPRIATELY TRAINED R.N.s IN THE HOME) SHOULD BE FURTHER DEVELOPED TO COVER A RANGE OF ANTEPARTUM PROBLEMS, INCLUDING THOSE LISTED ABOVE.

3. FREE ACCESS TO OUTPATIENT PERINATAL ASSESSMENT FACILITIES MUST BE MADE AVAILABLE TO PATIENTS THROUGHOUT THE PROVINCE THROUGH
   i) FETAL ASSESSMENT UNITS STAFFED WITH APPROPRIATELY TRAINED NURSES AND SUPERVISED BY OBSTETRICIANS IN WINNIPEG AND REGIONAL CENTRES.
   ii) FURTHER DEVELOPMENT OF THE ANTEPARTUM OUTREACH PROGRAM UTILIZING VISITATION BY R.N. AND OBSTETRICIAN TO SELECTED RURAL AREAS. A STUDY DONE IN THE ISLAND LAKE AREA DEMONSTRATES COST EFFECTIVENESS OF THIS PROGRAM (APPENDIX 1).
   iii) HOSTEL ACCOMMODATION IN WINNIPEG WITH FREQUENT VISITS TO FETAL ASSESSMENT UNITS IN EITHER THE HEALTH SCIENCES OR ST. BONIFACE FOR PATIENTS FROM MORE REMOTE AREAS.

   COMPLETE COVERAGE OF THE PROVINCE COULD BE PROVIDED BY A COMBINATION OF THESE THREE APPROACHES DEPENDING ON LOCAL RESOURCES AND GEOGRAPHIC LOCATION.

   THE COMMITTEE BELIEVES THAT FETAL ASSESSMENT BY REAL TIME ULTRASOUND SHOULD ALWAYS BE DONE AS PART OF A MORE GENERAL PERINATAL ASSESSMENT AS ULTRASOUND FINDINGS TAKEN IN ISOLATION MAY BE MISLEADING. THIS SHOULD BE THE RESPONSIBILITY OF AN INDIVIDUAL WITH SUFFICIENT OBSTETRIC EXPERIENCE TO PROVIDE

CONSULTATIVE PERINATAL ADVICE AND EDUCATION.

4. DIABETES EDUCATION AND MONITORING PROGRAMS SHOULD BE AVAILABLE AND FREELY ACCESSABLE TO ALL WOMEN, PREGNANT OR NON-PREGNANT, AT BOTH TERTIARY CARE CENTRES AND IN REGIONAL CENTERS. PROGRAMS DEALING WITH PREGNANT DIABETICS SHOULD BE STAFFED BY INTERNISTS WHO HAVE TRAINING, KNOWLEDGE, EXPERIENCE AND A SPECIAL INTEREST IN MANAGING DIABETES IN PREGNANCY.

5. THE AVAILABILITY OF ULTRASOUND SERVICES MUST BE IMPROVED TO ALLOW FOR MORE FREE AND IMMEDIATE ACCESS, THUS AVOIDING THE NECESSITY OF ADMITTING PATIENTS TO HOSPITAL TO HAVE ULTRASOUND DONE. IN THIS REGARD THE CURRENT PLAN TO EXPAND UTRASOUND FACILITIES IN THE PROVINCE MUST BE ACTIVELY PERSUED.

6. FUNDING MUST BE PROVIDED FOR EQUIPMENT FOR SELF-MONITORING PROGRAMS (EG. ELECTRONIC SPHYGMOMANOMETER AND GLUCOMETER).

7. HOSTEL ACCOMMODATION SHOULD BE MADE AVAILABLE IN CLOSE PROXIMITY TO THE TWO TERTIARY CARE HOSPITALS (AND PERHAPS IN ASSOCIATION WITH SOME REGIONAL HOSPITALS) AS AN INSURED SERVICE. IT IS RECOMMENDED THAT THESE HOSTELS SHOULD BE OF AN APARTMENT STYLE, WITH A LARGE DEGREE OF PATIENT AUTONOMY. PRENATAL EDUCATION AND SOCIAL SERVICES SHOULD BE AVAILABLE TO PATIENTS IN THESE SITUATIONS. FOR DIABETIC PATIENTS, DIETARY SERVICES SHOULD BE AVAILABLE EITHER IN THE HOSTEL OR BY ALLOWING THE PATIENT ACCESS TO THE CAFETERIA AND DIETARY SERVICE IN THE NEARBY HOSPITAL. THIS HOSTEL WOULD BE LARGELY FOR THE USE OF DISPLACED RURAL PATIENTS AND WOULD AVOID THE NECESSITY OF USING HOSPITAL BEDS FOR BOARDING PURPOSES.

8. A PERINATAL AIR AND GROUND AMBULANCE EVACUATION SYSTEM SHOULD BE MADE AVAILABLE THROUGHOUT THE PROVINCE FOR MATERNAL TRANSFER AND FOR TRANSPORT OF THE NEONATE WHEN THE DELIVERY OF A COMPROMISED BABY IN A RURAL AREA HAS BEEN UNAVOIDABLE.

9. PATIENT EDUCATION - FOR HIGH RISK ANTEPARTUM PATIENTS WHO ARE TO BE FOLLOWED IN THE HOME OR HOSTEL ENVIRONMENT, PROVISION MUST BE MADE FOR DETAILED PATIENT EDUCATION IN THE MOST EFFICIENT FASHION, PERHAPS WITH THE ASSISTANCE OF NURSE EDUCATORS AND A COMPREHENSIVE SERIES OF VIDEO TAPES.

10. PROFESSIONAL EDUCATION - THERE MUST BE A COORDINATED APPROACH TO CONTINUING PROFESSIONAL EDUCATION OF PHYSICIANS AND NURSES TO ENSURE HIGH STANDARDS OF PATIENT CARE AND TO ENCOURAGE EFFICIENT UTILIZATION OF SERVICES AND RESOURCES WITHIN THE CONTEXT OF A PROVINCIAL PERINATOLOGY PROGRAM. FINANCIAL RESOURCES MUST BE IDENTIFIED TO SUPPORT SUCH A CONTINUING PROFESSIONAL EDUCATION PROGRAM.

POSTPARTUM CARE AND BED UTILIZATION

1. THE ESSENTIALS OF POSTNATAL CARE, AS DEFINED IN THIS REPORT, SHOULD BE AVAILABLE TO ALL PATIENTS ON THE BASIS OF NEED, IRRESPECTIVE OF SOCIAL CLASS OR CULTURAL BACKGROUND.

2. CONSIDERATION SHOULD BE GIVEN TO REDUCING THE COST OF IN-HOSPITAL POSTPARTUM CARE BY DIVISION INTO TWO LEVELS AS FOLLOWS;
   - i) PROVISION OF A MINIMUM LEVEL OF MEDICAL AND NURSING CARE FOR NORMAL POSTPARTUM PATIENTS ALLOWING THEM TO RECOVER FROM THE PHYSIOLOGICAL EVENTS OF LABOUR WITH EMPHASIS ON EDUCATION AND HEALTH PROMOTION. THE ENVIRONMENT SHOULD BE OF AN AMBULATORY NATURE WITH EMPHASIS ON SELF-HELP, ROOMING IN, INTEGRATED FAMILY CENTERED CARE, BUFFET DINING, ETC. FEWER NURSES WILL BE REQUIRED BUT THEY SHOULD REMAIN HIGHLY SKILLED IN PERINATAL EDUCATION.
   - ii) PROVISION OF A HIGHER LEVEL OF MEDICAL/NURSING CARE WITH A MORE CONVENTIONAL NURSE/PATIENT STAFFING RATIO FOR PATIENTS HAVING COMPLICATED DELIVERIES.

3. POSTPARTUM CARE AND EDUCATION IN HOSPITAL PRIOR TO DISCHARGE SHOULD BE PROVIDED BY DEDICATED NURSING PERSONNEL. STEPS MUST BE TAKEN TO ENSURE THE EDUCATION OF NURSES TO CARRY OUT THESE SPECIALIZED FUNCTIONS IN MATERNAL AND CHILD HEALTH.

4. GIVEN PROPER BACKUP SERVICES THE IDEAL LENGTH OF STAY IN HOSPITAL THROUGHOUT MANITOBA FOLLOWING DELIVERY SHOULD BE AS FOLLOWS:

   PRIMIGRAVIDA - UP TO 72 HOURS WITH 75% OF PATIENTS BEING DISCHARGED IN 48 HOURS.
   MULTIPARA - 48 HOURS.
   CESAREAN SECTION - 4 DAYS.
   COMPLICATED VAGINAL DELIVERIES OR CESAREAN SECTION - DEPENDENT ON NATURE OF COMPLICATION.

5. POSTPARTUM EARLY DISCHARGE PROGRAMS MODELLED ON THE PILOT PROJECT AT ST. BONIFACE SHOULD BE SET UP TO SERVE THE WHOLE OF WINNIPEG AND EVENTUALLY THE WHOLE PROVINCE. ALTHOUGH THE PROGRAM MAY NOT BE REQUIRED OR DESIRED BY ALL IT SHOULD BE AVAILABLE TO ALL PATIENTS, WHO SHOULD BE SCREENED AS TO THEIR NEEDS ON ADMISSION TO THE UNIT AND REASSESSED PRIOR TO DISCHARGE.

6. PUBLIC HEALTH NURSES SHOULD HAVE SKILLS AND KNOWLEDGE UPGRADED AND UPDATED IN OBSTETRICS AND NEONATOLOGY FOR PARTICIPATION IN THIS PROGRAM; THEY SHOULD HAVE A CLOSE WORKING RELATIONSHIP WITH THE HOSPITAL(S) AND A PUBLIC HEALTH NURSE COORDINATOR SHOULD BE SITUATED IN EACH HOSPITAL.

7. A SYSTEM OF STANDARDIZED PERINATAL PATIENT EDUCATION MUST BE SET UP IN THE PROVINCE.

8. PHYSICIANS (OBSTETRICIANS, FAMILY PHYSICIANS AND PEDIATRICIANS) MUST BE EDUCATED ON THE SAFETY AND ADVANTAGES OF EARLY DISCHARGE AS PART OF A COORDINATED PROFESSIONAL EDUCATION PROGRAM.

9. HOSTEL ACCOMMODATIONS SHOULD BE PROVIDED AT THE TWO TERTIARY CARE HOSPITALS FOR POSTPARTUM PATIENTS AS AN INSURED SERVICE.

   A) TO ALLOW EARLY DISCHARGE OF OUT-OF-TOWN PATIENTS WITH THEIR BABIES WITH VISITATION BY EARLY DISCHARGE NURSES WHERE THESE SERVICES ARE NOT AVAILABLE IN THE COMMUNITY.
   B) TO ALLOW DISCHARGE OF OUT-OF-TOWN MOTHERS WHOSE BABIES ARE DETAINED IN THE NURSERIES ALLOWING FREQUENT VISITING AND BONDING.

   CONSIDERATION SHOULD ALSO BE GIVEN TO THE NEED FOR PROVISION OF HOSTELS OR BOARDING HOUSE NETWORKS AS AN INSURED SERVICE IN ASSOCIATION WITH REGIONAL HOSPITALS.

NEONATOLOGY

1. THE PROPOSED INCREASE IN NEONATAL INTENSIVE CARE BEDS SHOULD PROCEED AS A MATTER OF URGENCY TO ACHIEVE A MINIMUM OF 31 BETWEEN THE TWO HIGH RISK CENTRES, THIS NUMBER TO BE ADJUSTED FROM TIME TO TIME AS BIRTH RATES FLUCTUATE TO MAINTAIN THE MINIMUM REQUIRED NUMBER.

2. A PROGRAM SHOULD BE ESTABLISHED IN MANITOBA IMMEDIATELY TO EDUCATE NURSES TO ASSUME THE ROLE OF NEONATAL NURSE CLINICIAN IN ORDER TO MEET THE URGENT MANPOWER NEEDS OF THE TWO TERTIARY CARE CENTRES.

3. THE EXISTING MECHANISM FOR THE IDENTIFICATION OF THE HIGH RISK INFANT IN THE NEONATAL PERIOD SHOULD BE EXPANDED AND IMPLEMENTED AT BOTH TERTIARY CARE INSTITUTIONS WITH A SYSTEM OF FORMAL COMMUNICATION OF INFORMATION TO THE PHYSICIAN AND PUBLIC HEALTH NURSE IN THE COMMUNITY.

4. A FOLLOW-UP PROGRAM MUST BE AVAILABLE FOR EVALUATION OF NEURODEVELOPMENTAL OUTCOME OF HIGH RISK INFANTS DISCHARGED FROM BOTH NEONATAL INTENSIVE CARE UNITS TO ASSESS PROVIN-

CIALLY THE EFFICACY OF INTERVENTION AND THERAPY IN THE ANTEPARTUM, INTRAPARTUM AND NEONATAL PERIODS.

5. PROVISION MUST BE MADE TO INCLUDE IN THESE FOLLOW-UP PROGRAMS SERVICES AND THERAPIES REQUIRED BY HIGH RISK INFANTS TO ALLOW THEM TO DEVELOP TO THEIR FULL POTENTIAL AS INDIVIDUALS.

6. IN ALL CASES WHERE EARLY DISCHARGE IDENTIFICATION OF PATIENTS AT INCREASED FETAL OR NEONATAL RISK IS POSSIBLE THESE PATIENTS SHOULD BE TRANSFERRED TO A HIGH RISK CENTRE FOR DELIVERY.

7. ALL HOSPITALS OFFERING OBSTETRIC SERVICES SHOULD HAVE IN-HOUSE SKILLS FOR INFANT RESUSCITATION AND STABILIZATION AT THE TIME OF DELIVERY.

8. SUCH SKILLS SHOULD BE PROVIDED EITHER THROUGH THE AVAILABILITY OF A 24 HOUR ANAESTHESIA SERVICE (WITH AN APPROPRIATE RETENTION FEE) OR APPROPRIATE TRAINING SHOULD BE PROVIDED TO EQUIP DESIGNATED PHYSICIANS, NURSES OR RESPIRATORY TECHNOLOGISTS TO PERFORM THESE FUNCTIONS.

9. THE CURRENT NEONATAL TRANSPORT SYSTEM SHOULD BE EXTENDED TO SERVE THE WHOLE OF THE PROVINCE OF MANITOBA.

DEFINITION OF APPROPRIATE LEVELS OF CARE IN UNITS OUTSIDE OF WINNIPEG

1. THE COMMITTEE RECOMMENDS THAT M.H.S.C. REVIEW AND ACCEPT THE DOCUMENT "RECOMMENDED STANDARDS FOR MATERNAL AND NEWBORN CARE" AND THAT STEPS BE TAKEN TO ENSURE THAT THE LEVEL OF CARE AND FACILITIES OFFERING TERTIARY CARE SERVICE CONFORM TO THESE STANDARDS.

GYNECOLOGY

1. ADEQUATE FUNDING AND FACILITIES SHOULD BE PROVIDED FOR N.F.A. PROGRAMS WITH SEPARATE AND DEDICATED RECOVERY AREAS AND BEDS.

2. N.F.A. PROGRAMS SHOULD PROVIDE FOR EMERGENCY MINOR GYNECOLOGY PROCEDURES.

3. N.F.A. UNITS OR SURGICENTRES SHOULD HAVE READY ACCESS TO FULL HOSPITAL BACKUP FACILITIES.

4. HOSTELS SHOULD BE PROVIDED AT THE TWO TEACHING HOSPITALS FOR THE USE OF DISPLACED PATIENTS.

5. STEPS SHOULD BE TAKEN TO STANDARDIZE AND ENSURE COMPLETENESS OF PRE-OPERATIVE WORKUP FOR N.F.A. PATIENTS TO AVOID UNNECESSARY CANCELLATION. IT IS RECOMMENDED THAT A STANDARDIZED N.F.A. FORM OR FORMAT BE DEVELOPED WITH A WRITTEN INSTRUCTION SHEET FOR USE THROUGHOUT THE PROVINCE.

6. AN ADEQUATE NURSING EDUCATION PROGRAM SHOULD BE PROVIDED IN THE HOSPITAL PRIOR TO DISCHARGE AND A PUBLIC HEALTH NURSE FOLLOW-UP PROGRAM SHOULD BE DEVELOPED TO PROVIDE HOME VISITS FOR SELECTED POST-OPERATIVE EARLY DISCHARGE PATIENTS.

7. HOSPITAL OR DEPARTMENTAL ADMISSION AND DISCHARGE COMMITTEES SHOULD ACTIVELY MONITOR THE INDICATIONS FOR ADMISSION TO ACUTE CARE BEDS AS WELL AS LENGTH OF STAY AND SHOULD IMPLEMENT ADMISSION AND DISCHARGE POLICIES WITH CROSS INSTITUTIONAL COMPARISONS. THIS ACTIVITY SHOULD BE THE RESPONSIBILITY OF THE MEDICAL STAFF ASSOCIATION AT EACH HOSPITAL.

8. FUNDING SHOULD BE PROVIDED FOR SPECIALTY AMBULATORY PROGRAMS SUCH AS CERVICAL COLPOSCOPY AND CRYOTHERAPY, OVUM PICK-UP AND EMBRYO TRANSFER AND LASER SURGERY.

OBSTETRIC BED DISTRIBUTION AND UTILIZATION IN WINNIPEG

1. FIRST PRIORITY SHOULD BE GIVEN TO UPGRADING AND EXPANSION OF THE PERINATAL UNITS AT HEALTH SCIENCES CENTRE AND ST. BONIFACE TO ACCOMMODATE UP TO 4500 DELIVERIES PER YEAR AT EACH UNIT WITH PROVISION FOR BOTH HIGH RISK AND FAMILY CENTERED CARE.

2. FOLLOWING COMPLETION OF EXPANSION AT THE TERTIARY CARE CENTRES, CONSIDERATION SHOULD BE GIVEN TO CLOSURE OF ONE OBSTETRIC UNIT IN A COMMUNITY HOSPITAL; THE OBSTETRIC NEEDS OF THE CITY WOULD THEN BE SERVED BY TWO COMBINED HIGH RISK/LOW RISK CENTRES AND TWO COMMUNITY HOSPITAL OBSTETRIC UNITS.

3. THE SELECTION OF COMMUNITY HOSPITALS TO CONTINUE OBSTETRIC SERVICES SHOULD BE BASED ON THE CRITERIA SUGGESTED BY THE COMMITTEE AND THIS MUST BE DONE IN CONSULTATION WITH AN AD HOC COMMITTEE REPRESENTING THE PROFESSIONS AFFECTED.

4. GOVERNMENT AND THE HOSPITALS SHOULD ADOPT, AS A LONGTERM GOAL, THE IDEAL OF TWO OBSTETRIC UNITS TO SERVE THE CITY OF WINNIPEG, EACH WITH SEPARATE LOW RISK AND HIGH RISK AREAS BUT ALL UNDER ONE ROOF AND ONE FLOOR.

OBSTETRIC BED DISTRIBUTION AND UTILIZATION IN MANITOBA OUTSIDE WINNIPEG

1. THE COMMITTEE RECOMMENDS THAT M.H.S.C. AGAIN REVIEW THE PROPOSED MANITOBA PERINATAL EDUCATION PROGRAM AS A MATTER OF PRIORITY. THIS SHOULD BE DONE WITH A VIEW TO USING THIS AS A MECHANISM TO IMPROVE OBSTETRIC AND NEONATAL CARE IN THE RURAL AREAS AND TO FACILITATE DESIRABLE TRENDS, SUCH AS CONSOLIDATION AND REGIONALIZATION AS A VOLUNTARY, EVOLUTIONARY PROCESS. THIS PROGRAM SHOULD BE PART OF AN OVERALL PROVINCIAL PERINATAL PROGRAM.

2. IN ORDER TO DEVELOP AND MAINTAIN A VIABLE PROFESSIONAL EDUCATIONAL PROGRAM WITH SIGNIFICANT IMPACT THE COMMITTEE RECOMMENDS THE INCORPORATION OF THE RECOMMENDATIONS ON PAGE 31.

THE EXPANDED ROLE OF THE NURSE IN REPRODUCTIVE HEALTH CARE

1. AN AD HOC TASK FORCE SHOULD BE SET UP TO STUDY AND MAKE RECOMMENDATIONS ON THE ISSUE OF THE EXPANSION OF THE ROLE OF THE NURSE IN REPRODUCTIVE HEALTH CARE WITH PARTICULAR REFERENCE TO FETAL ASSESSMENT, NEONATAL INTENSIVE CARE, ANTEPARTUM CARE AND SURVEILLENCE, NURSE MIDWIFERY, SCREENING FOR GYNECOLOGIC DISEASE AND INVOLVEMENT IN SPECIALTY AREAS SUCH AS INFERTILITY.

2. NOTWITHSTANDING THE PRECEEDING RECOMMENDATION, THE COMMITTEE RECOMMENDS THAT, BECAUSE OF THE ACUTE MANPOWER SHORTAGE IN THE NEONATAL INTENSIVE CARE NURSERIES, A NEONATAL NURSE CLINICIAN TRAINING PROGRAM BE SET UP IMMEDIATELY AS ALREADY RECOMMENDED IN THE NEONATOLOGY SECTION.

PROFESSIONAL AND PATIENT EDUCATION

1. M.H.S.C. SHOULD AGAIN REVIEW THE PROPOSED MANITOBA PERINATAL EDUCATION PROGRAM (APPENDIX 7) AS A MATTER OF PRIORITY, RECOGNIZING THIS TO BE A MECHANISM FOR IMPROVING THE STANDARDS AND COST EFFECTIVENESS OF OBSTETRIC AND NEONATAL CARE IN RURAL AND URBAN AREAS.

   THIS PROGRAM:
   - SHOULD BE PART OF AN OVERALL PROVINCIAL PERINATAL PROGRAM.
   - SHOULD INCLUDE BOTH PHYSICIANS AND NURSES.

- SHOULD BE PROPERLY FUNDED WITH:
  1) AN ADEQUATE SESSIONAL FEE TO COMPENSATE PHYSICIANS (UNIVERSITY OR PRIVATE PRACTICE) FOR TIME LOST IN PRACTICE WHEN INVOLVED IN EDUCATIONAL ACTIVITIES.
  2) A SALARY FOR TWO OR THREE CORE PEOPLE WITH PROTECTED TIME TO ADEQUATELY PLAN, COORDINATE AND DELIVER SUCH EDUCATION.
- SHOULD MAKE USE OF TIME SAVING AND COST EFFECTIVE TEACHING METHODS SUCH AS TELECONFERENCING, VIDEO CASSETTE LIBRARY AND INCORPORATION OF PERINATAL EDUCATION IN MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS AND OF THE M.M.A.

2. THE CONTENT OF PRENATAL EDUCATION CLASSES SHOULD BE STANDARDIZED.

3. EDUCATORS SHOULD BE TRAINED AND LICENSED.

4. EDUCATION SHOULD EXTEND THROUGH THE PRENATAL, PERINATAL AND POSTNATAL PERIODS, EXTENDING INTO THE ELEVENTH MONTH.

5. WHERE IT IS PRACTICAL, AN ATTEMPT SHOULD BE MADE TO HAVE THE SAME INSTRUCTOR REMAIN WITH THE PATIENT THROUGHOUT.

6. THE GOAL MUST BE TO ENROLL ALL PATIENTS, BOTH PRIMIGRAVIDA AND MULTIPARA, AS STANDARDS CHANGE AND PATIENTS CIRCUMSTANCES CHANGE FROM PREGNANCY TO PREGNANCY.

7. CHILD SUPPORT SHOULD BEGIN WITH THE PATIENT'S FIRST PRENATAL VISIT AND/OR PRENATAL CLASS.

8. DIABETES EDUCATION PROGRAMS SHOULD BE AVAILABLE AND FREELY ACCESSABLE TO ALL WOMEN, PREGNANT AND NON-PREGNANT, AT BOTH TERTIARY CARE CENTRES AND IN REGIONAL CENTRES.

9. A STEERING GROUP SHOULD BE ESTABLISHED WITH MEDICAL AND NURSING REPRESENTATION TO SET UP A STANDARDIZED, STRUCTURED AND UNIFORM APPROACH TO PATIENT PERINATAL EDUCATION. THE GROUP WOULD HAVE RESPONSIBILITY FOR SETTING UP GUIDELINES, FOR INITIATING, COORDINATING AND MONITORING THE PROGRAM, AND

REPORT OF THE SUB-COMMITTEE
ON ONCOLOGY -
HEALTH SERVICES REVIEW COMMITTEE

DECEMBER 19, 1984

Sub-Committee Members:
Dr. Beecroft
Dr. A. Bishop
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Dr. J. Gillies
Dr. Krepart
Ms. J. Lutz
Mr. R.R. Publow
Dr. S. Shalev
Dr. H. Schipper
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Dr. L. Israels
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Ms. J. Searle
Ms. Betty Wong
Dr. W.D. MacDiarmid

sent out;
reviewed by
Steering Committee.

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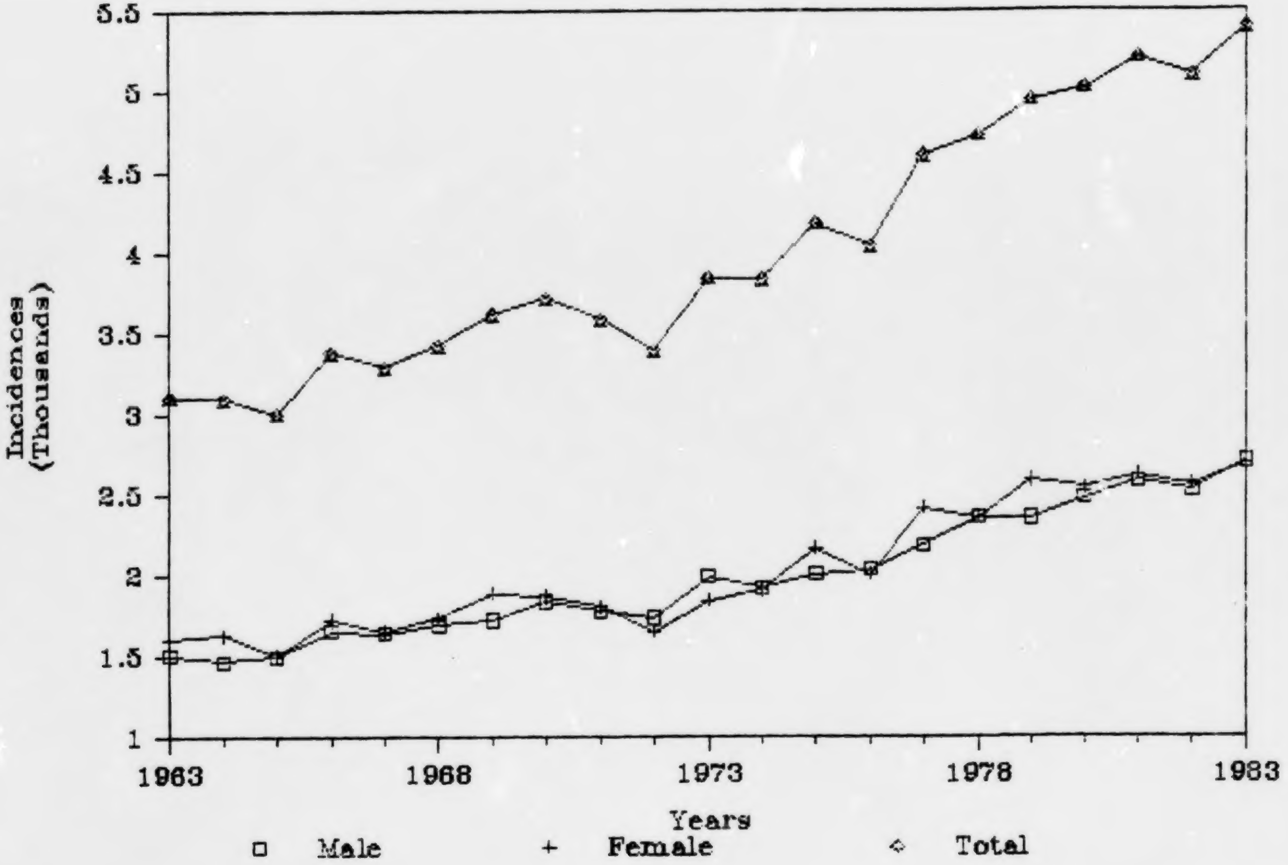
HEALTH SERVICES REVIEW COMMITTEE
SUBCOMMITTEE ON ONCOLOGY

INTRODUCTION

Before moving to the body of the report the Committee draws to your attention the accompanying Figure on the following page.
This figure indicates that the cancer incidence in Manitoba has increased from 3100 in 1963 to 5400 in 1983. This represents a 70% increase over a period of twenty years. We would also bring to your attention that in 1980 the total number of cancers at all sites was 4,895 as compared with the total expected cases of 3,850. These expected cases are the number of new cases of cancer expected within the province adjusted for sex and age as compared with the rest of Canada (Statistics Canada). These figures clearly show that the number of patients with malignant disease in Manitoba is increasing at a rate of approximately 3.5% per year and that for reasons as yet unclear the incidence rate would appear to be higher than that of the rest of the country. In the body of this report you will note that cancer services in the Province are deficient in a number of critical areas. The Committee strongly recommends that the province through its provincial cancer agency, The Manioba Cancer Treatment and Research Foundation, move towards meeting these needs and repairing the deficiencies within the provincial program. Unless this occurs standards of care will decline, training programs will wither, specialty staff will be lost, and the province will find itself with substandard care and forced to undertake a long and expensive rebuilding program to provide the citizens of Manitoba with an acceptable standard of cancer care. The movement towards the implementation of these recommendations can be done in an orderly and cost effective manner. However we urge government to move as quickly as possible as Manitoba faces a future in which cancer patients will receive care below acceptable standards.

2.

Cancer Incidence by Year



SUMMARY OF RECOMMENDATIONS

1. PREVENTION

(a) Radiation Protection

The Radiation Protection Service which is a joint function of the Department of Environment and Workplace Safety and Health and the Manitoba Cancer Treatment and Research Foundation should be maintained and consideration given to further expansion in areas of non-ionizing radiation.

The Manitoba Cancer Treatment and Research Foundation and the Province should increase their involvement in the monitoring of potential carcinogens in the workplace and in the environment and should both play a larger role in public education

(b) Cancer Screening

That should the National Cancer Institute Study on Breast Screening indicate that screening is an effective method of early detection that the present pilot screening program be retained and expanded.

That the Manitoba Cancer Treatment and Research Foundation maintain an interest in the screening for other malignancies should cost-effective procedures become available.

2. MEDICAL ONCOLOGY

(a) There is an urgent need for dedicated medical oncology beds at the MCTRF site. Planning should go forward immediately to establish a permanent facility for this group of in-patients.

(b) That the St. Boniface General Hospital be encouraged to proceed as soon as possible with the establishment of a dedicated ward for oncology patients.

(c) Increasing and upgrading the ambulatory services at the MCTRF and SBGH oncology units to encompass new techniques and support services.

RADIATION ONCOLOGY

(a) The complement of Radiation Oncologists should be immediately increased from 7 to 9.

(b) There is an urgent need for a Radiation Oncology in-patient unit at the MCTRF site to house patients receiving external radiation and brachytherapy. This should be done in immediate juxtaposition to a medical oncology unit and could be done on a ward combining radiation oncology patients with surgical and/or gynecological patients.

(c) That direct funding should be provided for a residency program of 6 residents or fellows for at least the next five years or until a continuing full complement of radiation oncologists within the Province is assured.

(d) Provision should be made for a second high energy linear accelerator and replacement of the existing 4MEV linear accelerator.

4. SURGICAL ONCOLOGY

(a) The Surgical Oncology Section at the MCTRF and affiliated units be expanded.

(b) The NFA facility at the MCTRF should be upgraded to allow its expanded use for biopsy and endoscopy thus reducing hospital admissions.

(c) The NFA facilities at the tertiary care hospitals be upgraded to reduce hospital admissions and length of hospital stay.

(d) That provision of surgical oncology beds be provided in conjunction with those of radiation oncology.

5. PEDIATRIC ONCOLOGY

(a) Pediatric oncology should be developed as a provincial program.

(b) It is recommended that all children with cancer be treated out of one centre with access to the facility and its resources being available to all pediatric oncologists.

(c) Ambulatory resources should be increased. This is less expensive than reverting to in-patient care.

(d) Radiotherapy expertise and availability must be improved.

(e) A serious feasibility study for a combined pediatric/adult marrow transplant program be undertaken immediately.

6. GYNECOLOGICAL ONCOLOGY

(a) That outpatient preventive programs for cancer of the cervix should be upgraded by an increased and more efficient Pap smear program with increased colposcopy, surgical and laser treatment facilities.

(b) That a physician education program and a public education program with a screening component be implemented for the early detection and prevention of endometrial and ovarian carcinoma.

(c) That there is an unacceptable delay in surgical scheduling for gynecological oncological surgery at the Health Sciences Centre which can be shortened by staffing existing operating room facilities.

7. OUTREACH

(a) That an expansion of the Outreach Program should include urban hospitals and additional rural centres.

(b) That there be a development of a microcomputer based cancer patient management system for the province.

8. PHYSICS

(a) That a simulator be installed at the SBGH oncology unit.

(b) That consideration be given to increased staffing fro simulation, treatment planning, and the servicing of radiation oncology consistent with the expansion of that Section.

9. NURSING

(a) That oncology nursing be developed in this Province as a specialty to produce improved patient care in both outpatient and in-patient settings.

(b) That there be continuing monitoring of standards of oncology nursing procedures within the province.

(c) That there be a larger role in public education and cancer prevention programs for nurses.

(d) That inpatient oncology nursing could be markedly improved by special training and the concentration of these nurses on specialized dedicated oncology wards.

10. SOCIAL WORK SERVICES

That there be a careful re-examination of the current method of delivery of Social Work Services to cancer patients throughout the province, for the purpose of augmenting and improving co-ordination of services.

11. VOLUNTARY SERVICES

The expansion of volunteer services throughout the province can be an effective means of improving patient support services and reducing costs.

Ia. PREVENTION

The ultimate objective in any disease is prevention rather than treatment. It is now known both on experimental and epidemiological grounds that a number of cancers arise from exposure to cancer causing or carcinogenic agents. Many of these occur in our environment, some are natural products others are chemicals or environmental pollutants, some are known and well documented, others not so well documented, others as yet unknown. The reduction or removal of these hazards not only makes both medical and economic sense and it is the obligation of the medical profession, the Manitoba Cancer Treatment and Research Foundation and government to reduce these risks to a minimum. The problem relates to (1) the identification of radiation hazards (2) quantitation of the risk (3) the cost-benefit ratio in terms of its removal and (4) government dedication to the process.

Radiation protection services have been a valuable resource for the protection of workers, patients and the public for many years. The service is now involved in the monitoring of new hazards or potential hazards in the areas of natural radioactivity and non-ionizing radiation. Provision for such increased monitoring should be considered a priority.

In the case of carcinogens where the carcinogen and its effects are documented steps toward removal or reduction in exposure must be pursued with vigor. This has not been the case to date. The primary carcinogens in our environment today are the polycyclic aromatic hydrocarbons in smoke, industrial, auto exhaust fumes and tobacco. Of these the most dangerous today is tobacco smoke. Although private agencies and the Canadian Cancer Society have waged vigorous campaigns government at all levels has been largely silent. Winnipeg City only recently adopted a diluted anti-smoking by-law. The number of cases of carcinoma of the lung in the Province in 1983 was 569. It is estimated that 80% of these are related to smoking. It is also estimated that each case will cost the Province $50,000 in hospital and medical services. The total is $28,450,000 of which $24,000,000 is a smoking related cost. This does not include the cost of other tobacco related tumors such as larynx, nasopharynx and bladder. All of these do not equal the morbidity and cost of the non-malignant disabling diseases due to smoking such as chronic obstructive lung disease, chronic bronchitis, emphysema, coronary artery disease, etc. Yet the Province has done little if anything to stop this expensive epidemic.

PROPOSALS

1. The Province should maintain its present radiation protection service which may require some expansion to deal with natural radiation sources such as the recent monitoring of water supplies in the Whiteshell and radon levels in Winnipeg.

2. Establish and maintain at the Manitoba Cancer Treatment and Research Foundation a group directly interested and involved in studies of carcinogens to maintain local expertise in this field. This group to work with government to help assess and monitor known industrial carcinogens (asbestos, cadmium, radioactive materials,etc).

3. The Province to mount a vigorous advertising campaign (bill-boards, school education, etc) on the dangers of smoking.

4. The Manitoba Cancer Treatment and Research Foundation and the Province work with the Canadian Cancer Society in furthering cancer education in the province and spreading information on preventive measures (including sun-exposure, diet, etc) and early detection.

1b. SCREENING

This section specifically excludes screening for gynecological neoplasms which is covered under Section VI. (1) Colorectal Neoplasms:

It is appropriate for the Province to support individual patient care approaches sometimes deemed "screening," such as periodic stool analysis in individuals aged 40 or more years and other high risk groups. Application of any screening methodology for colorectal carcinoma to general populations have not as yet demonstrated convincing survival benefits and are not cost effective. Hence, while appropriate research in such areas of screening are to be recommended formal screening programmes for cancers of the gastrointestinal tract are not currently supportable on the basis of present data.

(2) Lung and GU Tract:

Screening general populations for carcinomas of the respiratory and genitourinary tract remain at a research level and implementation of formal programs cannot be recommended in the foreseeable future.

(3) Breast:

The one exception to the above negative statements with respect to current screening applies to carcinoma of the female breast. The widespread establishment of the "breast cancer detection demonstration projects" in the United States in the past decade was predicated largely upon the demonstration earlier by the Health Insurance Plan of New York that periodic annual screening with a combination of physical examination and mammography led to approximately a 1/3 reduction mortality in the women studied and screened compared to unscreened controls. This apparent benefit was confined to those women greater than 50 years (up to the maximum age at entry of 64 years in the study). It has not been entirely clear however, as to which components of such screening: (that is radiological mammography vs physical clinical examination) were most important.

The current National Breast Screening Study is attempting to resolve that question and extend the evaluation of screening with both modalities to a younger age group(40-49 years). Conceivably these results could lead to a stronger basis for general population screening within the next five years. The Manitoba Cancer Foundation houses the Manitoba Unit of the current National Breast Cancer Screening Study. Termination of this study as to active screening is expected in 1987. At the present time, it would seem that recommendations for annual screening of women aged 50 years and older, with combined physical examination and mammography, as a health care delivery program involving specific high risk groups which may be identified in the interim will be appropriate. Operating expenses including salaries and supplies would approximate $250,000 per annum as projected from present costs plus the establishment of a second screening centre at a capital cost of $100,000.

(4) Proposal

Consideration should be given to selected application of screening for secondary prevention of breast cancer in high risk population subsets when the current participation of the Manitoba unit of the National Breast Screening Study is completed (1987).

II MEDICAL ONCOLOGY

1. Inpatient Care

The two tertiary care teaching hospitals in Winnipeg are the major referral centres for inpatient intensive chemotherapy. As new drugs and drug combinations become available it is possible to aggressively treat an increasing number of tumors with promise of remission or cure. These advances in aggressive cancer chemotherapy have produced a major impact on remission duration, survival and cure in the leukemias, Hodgkin's Disease, non-Hodgkin's lymphomas, carcinoma of the breast and more recently in some forms of carcinoma of the lung. These patients all require specialized ward care and special supportive care systems. These must deal with the multiplicity of needs of patients whose hematological and immune defence systems have been severely crippled either by their disease or by therapy which makes them extraordinarily susceptible to life threatening infections. Experience in all major cancer treatment centres indicates that these patients can only be cared for effectively in a well planned, dedicated, defined facility with a medical, nursing and support staff specially trained and oriented towards this group of patients. Manitoba is one of only a few places in North America or indeed throughout the western world in which a major centre does not have such dedicated facilities. The absence of such facilities daily compromises the lives and welfare of these patients and has resulted in numerous episodes of deficient patient care and some catastrophic events. The Manitoba Cancer Treatment and Research Foundation has vigorously suggested the establishment of these units at the Health Sciences Centre and at the St. Boniface Hospital. At this time St. Boniface Hospital is moving to establish such a dedicated facility. The Health Sciences Centre has not moved towards this idea and the establishment of such a service is not a priority at that hospital. The establishment of such units will not only improve cancer treatment but will impact positively on other ward services within the tertiary care hospital. This will include the removal of these patients from other areas in the hospital where they are inappropriately housed and at present produce a major burden on untrained staff. These patients are in the case of Health Sciences Centre presently scattered throughout various wards and various disciplines frequently being housed on completely inappropriate wards including ophthalmology and orthopaedics. As these patients are presently scattered throughout the hospital systems such a dedicated area would serve to bring them together and to make possible the implementation of optimal therapy. This would serve to:

(1) concentrate medical expertise in a single dedicated unit

(2) concentrate oncology nursing staff who administer cytotoxic chemotherapy and provide essential supportive care. Such chemotherapy nurses are now scattered through the hospital.

(3) maximize the expertise of ward nursing staff in handling cytotoxic chemotherapy

(4) maximize the expertise required in managing patients' life-threatening bone marrow suppression and granulocytopenia and maximize efficient liaisons and participation with Infectious Disease services.

(5) minimize the impact of caring for these 'labour intensive' patients on other wards and improve efficiency of bed utilization (avoid closure of two bed units for single immunocompromised patients).

(6) allow for more adequate monitoring/supervision and medical audit

(7) promote appropriate development of specialized pharmacy participation (on site "satellite" pharmacist preparation of antineoplastic agents).

(8) promote enhanced education of under and postgraduate teaching of students, residents, nurses, and fellows involved in the care of such patients.

(9) promote the appropriate application of investigative treatment programs (clinical protocols) for such patients.

(10) use the expertise of such a unit could also be used as an efficient base for more routine chemotherapy and as a base for outpatient chemotherapy.

(11) serve as a base for the eventual development of marrow transplant services. Marrow transplant procedures have now moved from the experimental through the developmental stages and now have been simplified to the point where they can be implemented in regional centres. The cost to the province of marrow transplantation in 1983 was $1,078,908. Serious consideration should be given following the establishment of such a unit to the development of a transplant centre. This should be a combined pediatric/adult facility and could grow out of a dedicated intensive care oncology area. At the present time, and in view of the substandard facilities, marrow transplantation is out of the question for this province. However present developments suggest that the procedure will increase in frequency at least over the next ten years and that the cost of doing this out of province will similarly increase. It is in the financial interests of the province as well as in the medical, scientific and educational interests of the province to move towards the establishment of such a unit.

OUTPATIENT CARE

For patient convenience, cost, and physician efficiency outpatient care is the ultimate goal and has represented the vast majority of physician and nursing time commitments for many years at the two MCTRF outpatient units. These ambulatory clinics operate with the services of oncologists, chemotherapy nurses, and volunteer personnel. The following table documents current (1983) patient volumes:

	New Patients	Follow-up Visits	Treatment Courses
St. Bon. Med. Onc. Clinic	377	4257	3753
MCTRF Med. Onc. Clinic	838	9795	4301

Developmental approaches to reduce the necessity for hospitalization should include the following:

(a) Further study on the use of indwelling catheters so patients can receive longer term chemotherapy on an outpatient basis.

(b) Portable infustion pump programes so that present day treatment requiring admission may alternatively be performed on an outpatient basis.

(c) Utilizing nursing expertise to increase efficiency of standardized programs.

(d) Further development of innovative and effective drug treatments will depend upon the ability to continue and extend our participation in the clinical trials which bring the forefront of developmental medicine to the individual cancer patient. The MCTRF's ability to participate in these programmes is already curtailed by a net loss of one full time equivalent (FTE) oncologist over recent years, during a time period that patient volumes have significantly increased. Hence effective recruitment of medical oncologists as soon as possible is imperative.

(e) Increased use of Pharmacy service within these clinics to assist quality control.

(d) It is predicted that oncology will become more complex and patient treatment more demanding. Within the outpatient setting some care can be delegated to community physicians and nurses for standard protocols through the Outreach Program. It is recommended that in the interest of the total Provincial Program that the Outreach Program be extended to all urban hospitals and to major private clinics to allow registration, documentation and an improved statistical base for assessing cancer care within the province. This proposal for expansion of the Manitoba Outreach Program was submitted to MHSC in early 1984; its implementation remains an integral component of these recommendations.

RECOMMENDATIONS

1. That all intensive combination chemotherapy which may result in granulocytopenia be carried out at the two tertiary care hospitals.

2. The St. Boniface Hospital is presently moving to establish a dedicated oncology ward for tertiary care patients requiring chemotherapy. It is recommended that this move be completed within the next 12 to 18 months.

3. It is strongly recommended that dedicated oncology beds be linked directly to the Provincial Cancer Program by the construction of a combined medical oncology, radiation oncology and surgical oncology facility above the present Manitoba Cancer Treatment and Research Foundation. This unit would be the primary responsibility of the Foundation with the medical and nursing services being provided under the Affiliation Agreement of the Foundation and the Health Sciences Centre.

4. Expansion and improvement of existing outpatient programs including an increase in the number of medical oncologists.

III RADIATION ONCOLOGY

Professional Staff:

A Radiotherapy Centre serving a population of 1 million requires 9.0 F.T.E. Radiation Oncologists. The MCTRF now has an approved complement of 7.0. Saskatchewan with a similar population has 10. To maintain this staffing requires a funded training program with 6 residents or fellows.

Anticipated referrals will increase from a current 1350 per annum to about 2000 new patients per annum (50% increase) due to rising incidence and extension of treatment to more patients with new techniques. This will result in an increase of about 50% in patient visits over the next 5-10 years.

Patient follow-up visits are in part managed by physician Clinical Assistants, i.e. non-Oncologists, and radiotherapy currently utilizes 0.4 F.T.E. This should be expanded to 1.5 F.T.E.'s until such time as a full complement of radiotherapists is achieved.
A corresponding increase in clinical, nursing, social work and volunteer staff is envisioned.

CT Imaging and NMR:

If adequate facilities are provided for the purpose of staging, treatment planning and follow-up, at least 3000 procedures a year are required for the present patient needs.

NMR is currently being evaluated. Among other advantages it gives no ionizing radiation to the patient. This is of projected value but would be shared with other departments.

Technology Staffing:

The number of patients treated in 1976 was 1596 and this increased to 2324 in 1983. An additional 2.5 F.T.E. technologists are required in 1985 and a further 2.25 F.T.E. projected for 1990. The current intake of 5 technology students per annum should be maintained and is well within the capacity of our training school and adequate to ensure a supply of trained technologists for the province.

Simulator/Treatment Planning Technologists - We anticipate a 50% increase in demand for these procedurs with an appropriate level of staffing (Physics - Section VIII).

Radiotherapy Equipment:

Department statistics reveal that over 90% of treatments are currently administered on megavoltage units. of the remainder, about 2% are adequately treated with orthovoltage machinery (deep x-ray), or with superficial x-ray therapy for skin lesions. The MCTRF currently operates one DXC unit (Siemens) and three "superficial" units with varying physical characteristics. It is recommended that the latter should remain in service indefinitely and that they will continue with the present very low utilization factor which will result in minimal expenditure for maintenance and replacement parts.

Megavoltage Therapy:

Historical - Manitoba was one of the earliest centres to enter the supervoltage era of radiotherapy when in 1953, we purchased a Cobalt machine from AECL, production model #2, and installed it in the Forlong annex of WGH. This unit was relocated in the new MCTRF building and remained in operation until it was replaced by the 4MV SHM Linac in 1974. A similar Cobalt unit was installed in SBGH in 1955. In 1963, a high energy Betatron replaced it as the main source of penetrating radiation, and it in turn was supplanted by the Sagittaire Linac in 1977. The Sagittaire was the first of our machines to utilized fully the isocentric design that permits us to treat multiple ports without the patient having to turn over between treatments.

Work Load - The advanced design features of the Sagittaire combined with its sharply defined and very penetrating radiations have made it the machine of choice for all patients whose tumors are located deep in the body and a significant survival benefit has been demonstrated in a number of studies. As a result, the work load (port count) has more than doubled since its first full year of operation in 1978 with the corresponding decline in the use of Cobalt therapy. The machine is currently running at up to 150 ports per day, some 50% in excess of its rated capacity and operates 12 to 14 hours per day, commencing at 0700 hours.

Anticipated Needs - The incidence of cancer reported in the province continues to increase, 40% in the past 10 years (from 3848 to 5400 cases) and most marked in sites such as lung, breast, uterus, colorectal and prostate and we must anticipate continued demand on radiotherapy services. In addition, an increase in the median survival of patients living with disease because of better management and more effective treatment, points to increased future demand for further palliation with radiotherapy. We must anticipate a continuing increase in the demand for high energy photon therapy.

We must point out that technology improvements in supervoltage machines resulted in two energy levels being established:

a) photon beams of about 20 MV suited primarily for deep seated tumors (eg. Sagittaire).

b) Linacs operating in the 6 to 10 MV range, best suited for extended field therapy and Head and Neck.

The useful life for such a machine was stated to be 12 to 15 years, after which replacement parts would no longer be available. Such machines were produced 10 years ago, and continue to provide excellent service. Technical developments that have occurred since that time have made current models more reliable and more compact, their expendable components are more durable and less expensive to replace, and almost all are now isocentrically mounted to increase the patient handling capacity while maintaining precision. However, the radiation which they produce ha not been improved upon and therefore we recommend that every effort be made to keep these units in service for as long as possible.

Sagittaire 25 MV Linac - This unit was installed in MCF and came into service in November 1977. Its work load has increased progressively since that time and is currently some 50% in excess of its rated capacity of 100 ports per day. Every effort should be made to keep this machine in service as long as possible. This model is still being produced by CGR in Europe, and spare parts will be available for at least another 15 years. It is likely that it will require a major overhaul within a number of years and this should be assessed by the manufacturer's representatives.

AECL Cobalt Machine (Theratron F) - This machine was installed in MCF in 1963, and should be retired in 1985.

4 MV SHM Linac - This machine has carried a heavy patient load since its installation in December 1974 and should be phased out in 1987. It is recommended that it be replaced by a 6 MV isocentrically mounted linear accelerator in that same location.

Dual Energy Isocentrically Mounted Linac (8/18 MV) - This is required immediately to relieve the excessive work load on the Sagittaire and to provide back-up for the SHM. A recent architectural/engineering survey has indicated that it might be housed in a new treatment room adjacent to the MCTRF building with access to the basement treatment floor through the old Betatron Room and a cost estimate has been submitted by these consultants. This should be considered along with other proposed construction for the MCTRF building. Alternatively consideration should be given to installing this in the treatment room at SBGH. The recently purchased AECL isocentric Cobalt unit installed there might be relocated in the Theratron F Treatment Room at MCF (see above). The "Betatron Room" could then be held in reserve and could, at some future date, house an additional supervoltage unit if the patient load warrants.

HYPERTHERMIA

This treatment modality has gained acceptance and will, we feel, have established its place in the armamentarium within a very few years as the technology improves. Its cost and floor space requirements are modest. The requirements are 1 F.T.E. Radiotherapy Technologist to operate this with possible increase to 2 when it is fully operational.

SIMULATORS

The Picker Simulator at MCF came into service in 1971, but was completely renovated in 1983 and should remain in service for at least a further 10 years. It is anticipated that the recently acquired Picker Simulator will receive a similar overhaul and be placed in operation at SBGH. The AECL Therasim was installed at MCF in March 1982 and should remain in full service for sometime.

PATIENT ACCOMMODATION:

Inpatients - There is an urgent need for the establishment of a Radiation/Surgical Oncology Ward, both at the Foundation and SBGH. This would be available for the patients undergoing hospital-type investigation, in addition to external radiotherapy and brachytherapy. A minimum of 25 beds should be provided. Currently the Gynecology patients receiving Cesium insertions are housed inappropriately at HSC. Patients with implants at other body sites are housed on various services, (mostly Head and Neck) at HSC. All should be accommodated on a dedicated Radiation Oncology ward where skilled nursing is available and adequate protective devices are provided. It would be appropriate to locate this ward adjacent to the Medical Oncology Unit. Such a combined unit could best be achieved by locating it in new construction above the present MCTRF building.

Hostel - The Lennox Bell Lodge has provided a much needed service to out of town residents who are ambulant and the demand for the service will increase. As there is a need for a higher degree of care for some patients who are not fully ambulatory but do not require hospitalization consideration should be given to increased services for this type of patient.

IV SURGICAL ONCOLOGY

Advances in anesthesia, critical care and reconstructive techniques afford the surgeon unprecedented opportunities to treat patients with malignant disease. However, the safe conduct of a surgical procedure does not guarantee ultimate cure.

A formal program in Surgical Oncology does not exist in Manitoba. Routine problems are dealt with by surgeons who have technical competence, but no extra training to provide additional expertise in Oncology. More complex cases are referred to the Manitoba Cancer Treatment and Research Foundation (MCTRF), Health Sciences Centre and St. Boniface General Hospital for a further opinion and/or management. Over the next 5-10 years a strong core of 4-6 surgical oncologists should become available to provide consultation services and develop appropriate treatment programs for both complex and common surgical oncology problems.

Head and Neck Oncology:

Practise patterns will certainly change in the next 10 years. In the management of Head and Neck malignancies, more patients will be eligible for aggressive surgical resection including base of skull surgery and craniofacial surgery. More patients will be receiving planned multimodality therapy with radiotherapy and chemotherapy being utilized in conjunction with surgical excision. Laser surgery and cryosurgery should also be added to our surgical armamenterium. Surgery will also have a role in voice rehabilitation. This division of Surgical Oncology deals with a small but complex patient population. These individuals should be treated in a Head and Neck Oncology Unit by dedicated staff with special expertise and interest in the management of the many facets of their care. The Head and Neck Unit at the MCTRF represents a significant first effort to realize such a facility. It must be expanded to offer its services to the entire province. A central unit would provide efficient access to diagnostic and therapeutic equipment, provide better multidisciplinary treatment planning, yield higher cure rates, and enhance the quality of life through effective rehabilitation.

Manitoba Cancer Treatment and Research Foundation

Most routine surgical oncology problems are effectively being dealt with. As the management of cancer patients become more complex a multidisciplinary team approach achieves the best results. Participation by Surgical Oncologists at the M.C.T.R.F. and its affiliated hospitals compliments existing expertise in chemotherapy and radiotherapy.

To provide on site consultation services, a Section of Surgical Oncology must be developed at the M.C.T.R.F., as well as the H.S.C. and St. Boniface Hospitals. Administrative office space, clinic space, as well as clinical and nursing support staff dedicated to the Section of Surgical Oncology at the M.C.T.R.F. will have to be obtained. At the present time, consultation, treatment planning and follow-up for general surgical oncology problems, including head and neck oncology, and for urologic oncolcgy problems is being provided. This service will soon be expanded to include pulmonary and thoracic esophageal onolcogy.

There are many areas, where the surgical oncologist will be participating in multidisciplinary patient care. A few of these areas present and future are:

1. Breast cancer: Conservative breast surgery, with postoperative radiation to the remaining breast tissue is becoming an alternative treatment of breast cancer in some patients. Adjuvant chemotherapy for Stage II patients and trials for Stage I patients have been active for several years.

2. Soft tissue sarcoma: Much interest is being shown in combined treatment with chemotherapy and radiation to extremity lesions. This is followed by conservative surgical excision with limb preservation.

3. G.I. malignancies: Surgery and radiation therapy for esophageal and colorectal cancers being evaluated in many centres in the hope that improved survival can be achieved. These results have not been dramatic to date, but further evaluation of certain patient subsets is required. Attempts to improve results with adjuvant chemotherapy in G.I. malignancies are ongoing in many centres. Optomistic results are not being achieved on most fronts to date. Obviously more work is needed in these areas in the future.

4. Angio-access: The surgical oncologist can provide the access for chemotherapeutic agents to be delivered to specific organs, for example the liver, and also on a continuous basis on the ambulatory patients through the new implantable infusion pumps.

5. Metastatic disease: More aggressive surgical excision of metastatic disease on the liver, lung or brains is being carried out today. This trend will likely continue. Decisions to proceed with this form of surgery are usually made in conjunction with the medical and radiation oncologist.

These are only a few examples of the close liason necessary between the medical, radiation and surgical oncologist. This liason will be improved with dedicated oncology wards in the teaching hospitals and at the M.C.T.R.F.

Inpatient Services

Dedicated surgical oncology beds at both St. Boniface and the H.S.C. should be allocated to provide consistent excellence in patient care for oncology patients who have special problems relating to their type of surgery or multidisciplinary treatment. These beds would hopefully be geographically close to both medical and radiation oncology dedicated beds. If patient care beds are added to the M.C.T.R.F., surgical oncology should have access to a number of these for those patients undergoing diagnostic staging and therapeutic procedures.

Multidisciplinary treatment planning and therapy could be greatly facilitated by these special care units. The units would evolve to meet provincial needs and avoid duplication. The benefits of dedicated beds for oncology patients have been outlined elsewhere in this brief and in both the radiation and medical oncology briefs.

Outpatient Services

To try and curtail the rising cost of medical care more and more diagnostic and therapeutic procedures are being carved out on an outpatient basis. This trend will continue and therefore outpatient facilities must be upgraded at hospitals throughout the province.

Outpatient facilities are to be expanded at the H.S.C., but demands on these facilities will be great. To provide improved availability of diagnostic and therapeutic procedures the outpatient facilities at the M.C.T.R.F. should be improved. One operating room is now being used on a part-time basis by gynecology, oncology and surgical oncology. Diagnostic biopsies of skin lesions, lymph nodes, breast masses and intraoral lesions are being carried out now on a regular basis. Fiberoptic nasendoscopic is available, but under utilized to date.

The capability of this suite should be expanded in the near future to include upper aerodigestive tract endoscopy under local anesthesia. This would include laryngoscopy, bronchoscopy, esophagoscopy, as well as gastroduodenoscopy. Flexible sigmoidoscopy and colonoscopy should be included in the next 5 years and consideration of cystoscopy capability, if the numbers would justify its implementation. This outpatient endoscopy capability would greatly improve diagnostic workup and patient follow-up. At the present time many head and neck oncology patients receive less than optional follow-up because post-treatment endoscopy require admission to hospital and operating room time, which is difficult to obtain on many occasions.

In the future general anesthesia facilities should be implemented to further expand this outpatient scope of this facility. This would require a significant amount of new equipment and space for a pre- and postoperative holding area. If patient care beds were added to the M.C.T.R.F., the general anesthesia capability would be a very important addition to this operating room.

Line placement for angio access could be carried out in the present facility with minimal changes. Implantable pumps and line insertions could also be placed if appropriate expertise and equipment was available. This capability available within the M.C.T.R.F. would facilitate more rapid and efficient service for the oncology patient.

The Future

Goals for surgical oncology in the next 5-10 years are:

1. 4-6 Surgical Oncologists participating in a well organized University Program based at the M.C.T.R.F. and the two teaching hospitals.

2. An active Section of Surgical Oncology, within the M.C.T.R.F., to provide on site expertise in multidisciplinary problems and patient care.

3. Dedicated surgical oncology beds within both the H.S.C. and St. Boniface and the M.C.T.R.F., if Foundation patient care beds are developed.

4. Improved and expanded outpatient facilities at the M.C.T.R.F., as well as the H.S.C. and St. Boniface.

V. PEDIATRICS

Pediatric oncology is a multi-disciplinary specialty involving acute and chronic care, and requiring resources which extend from traditional in-patient acute care to tertiary ambulatory facilities and the utilization of community resources.

The rapidity with which improvements in prognosis has occurred in pediatric oncology in the last two decades has changed the concepts of care of these children, from one of an acute illness to one of a chronic illness with acute episodes. In two decades the overall long term survival rates have increased from 15% to 65%.

The majority of patients are treated and diagnosed in the program at the Children's Hospital and Manitoba Cancer Treatment and Research Foundation (CH-MCTRF) with a small number being treated and diagnosed at St. Boniface Hospital. Between 1973 and 1983 there were 470 children diagnosed with neoplastic disease (see table 1), 295 were diagnosed at Children's Hospital, 67 at St. Boniface and 108 at other hospitals. Of the 470 patients, 415 were treated at the CH-MCTRF, 49 at St. Boniface and 6 were referred back to their own provincial centres.

Although the incidence of pediatric cancer has not significantly increased in the last decade in Manitoba, the improved survival has dramatically increased the total number of patients under active and follow-up treatment. As seen in table 2, in 1971 there were 23 patients on active therapy and 12 patients off therapy in the CH-MCTRF program. As of October, 1984, there were 109 children on therapy and 134 on off-therapy follow-up.

In spite of the increased complexity of therapy the majority of patients are treated on an ambulatory basis. Table 3 compares 1971 and 1983, number of out-patient clinic visits and chemotherapy treatments at the MCTRF. These figures do not include radiotherapy.

Although the majority of patients are treated on an ambulatory basis, those patients who are treated in hospital are either those receiving the most complex therapeutic regimes, or those who are very ill from their disease or complications of therapy. Therefore, their hospitalizations tend to be prolonged (see table 4). The admissions to the rural hospitals tend to be short, primarily because they are usually rapidly transferred to either the Children's Hospital or St. Boniface.

Today the majority of children with cancer will be cured of their disease, but the cost to the child and his or her family is high. Pediatric oncology programs must have as their therapeutic objective, not just children cured of cancer, but children who are healthy and developmentally on par with their peer groups. Since curing cancer is a possibility, addressing the health problems of the short and long term effects of the disease and its therapy on both the physical and psychosocial development of the child, becomes an absolute necessity.

Therapy in pediatric oncology, therefore, requires a multi-discipline approach involving physicians, nurses, psychosocial services, physiotherapy and other rehabilitation services, as well as the development of school and home therapy programs. This multi-discipline requirement occurring in multi settings of a defined number of patients, can only be efficiently performed under a provincial program.

The therapy of the dying child requires as much thought, care and expertise from the various team members as they extend to the children with successful therapy. At present 75% of the children treated at CH-MCTRF, who die from their illness, do so at home. This is not possible without a lot of support from the treatment team being available to the family. The dying child does not need a whole new set of therapists during the terminal phase of his illness, but does need the support and expertise of those who have treated him or her throughout the illness. There is no need for a hospice approach to care for the dying child with cancer in Manitoba, but there is a need for appropriate resources for home terminal programs, and if hospitalization is required, to be under the care of those who already are familiar to the patient and his or her family. The therapeutic resources for children with cancer are a problem in the following areas:

1. *Ambulatory Care*

   The resources for the various ambulatory programs are under-funded and have not kept pace with the shift from in-patient to out-patient therapy. If the shift in therapy practices is to remain as they should in the direction of ambulatory care, these must be up-graded. To be successful in these ambulatory programs, the therapy personnel must be able to move from ambulatory clinics into the hospital and out into the home, school and community. Children who could be investigated or treated on an ambulatory basis have required admission in order to obtain CT scanning, or physiotherapy, since the limited resources have forced the situation where in-patients have priority.

2. *Radiotherapy*

   Radiotherapy for children should be under the direction of one or two radiotherapists in order to develop the expertise required for pediatric patients. The current short-fall of radiotherapists has created extreme difficulties in obtaining quality care.

3. *Marrow Transplant*

   Pediatric oncology requires the availability of marrow transplant resources. A large amount of money is flowing out of province for this therapy at present and a few patients are not able to obtain this therapy when needed because of bed shortages in the referral centres, or because social reasons prohibit the transfer of the child, donor and parent to a distant centre. The feasibility of development of a transplant centre for both children and adults should be seriously studied.

Conclusions and Recommendations

1. Pediatric oncology should be developed as a provincial program.
2. It is recommended that all children with cancer be treated out of one centre with access to the facility and its resources being available to all pediatric oncologists.
3. Ambulatory resources must be increased. This is less expensive than reverting to in-patient care.
4. Radiotherapy expertise and availability must be improved.
5. A serious feasibility study for a marrow transplant program should be undertaken.

Table 1

1973-1983 AGE 15 YEARS OR LESS

	CH/MCF	ST. BONIFACE	OTHER	TOTAL
Diagnosis	295	67	108*	470
Treatment	425	49	6	470

*34/108 Out of Province.

Table 2

CH/MCTRF PROGRAM

	ON THERAPY	OFF THERAPY
1971	23	12
1984	109	134

Table 3

CH/MCTRF OUT-PATIENTS

	PATIENT VISITS	CHEMOTHERAPY COURSES
1971	208	54
1983	1,926	916

Table 4

HOSPITAL ADMISSIONS FISCAL YEAR 83/84 (MHSC)

	CH/MCTRF	ST. BONIFACE	RURAL
Number	105	33	29
Average Stay	10.2	8.4	2.7

VI GYNECOLOGIC ONCOLOGY

1. Gynecologic malignancies comprise 11.2% of the total reported carcinomas in Manitoba (571/5,104*); 83% of these tumors are endometrial, cervical or ovarian carcinomas. The treatment of gynecologic malignancies usually involve radiotherapy, chemotherapy and/or simple or radical surgery and often a combination of two or three of these modalities are selected. At present, all three of these modalities are taxed, either due to O.R. time, bed shortages or physical abilities to handle patient volumes and investigations. Waiting periods of six to eight weeks for major surgical procedures are routine. This waiting period combined with the additional waiting period for investigations, i.e. scans, and X-rays, even further prolong the diagnosis to treatment interval. Further increases in the aging population will surely predispose to a further strain on this already taxed system.

Manitoba's population base resides mainly in the south, with most of the population having close access to cancer treatment facilities. Radiotherapy and tertiary hospital facilities for the often multimodality treatment of gynecological malignancy are available only at the Manitoba Cancer Treatment and Research Foundation (MCTRF) and/or the Health Sciences Centre and St. Boniface General Hospital. Over 50% of patients with endometrial carcinoma and over 90% of patients with invasive cervical carcinoma will require radiotherapy for their tumors and will have to be treated at the MCTRF. At present, approximately 70% of all gynecological malignancies are assessed and/or treated at the MCTRF or the two tertiary centres in Winnipeg. One would expect with the increasing sophistication of radiotherapy and chemotherapy, as well as radical pelvic surgery, this number will tend to increase in the future with primary and secondary hospitals not being able to cope with the treatment procedures and complications because of lack of equipment, i.e. radiotherapy or tertiary backup (i.e. infectious disease, T.P.N., I.C.U. facilities, etc).

Few radical gynecologic surgical procedures are undertaken outside the above mentioned facilities. Greater than 95% of all radical vulvectomies, radical hysterectomies, pelvic exenterations and Second Look operations were undertaken at either the Women's Hospital or St. Boniface Hospital in the last four years. With the only trained individuals and tertiary facilities available in these areas, this is unlikely to change in the near future as a duplication of the tertiary facilities is not likely.

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* M.C.T.R.F. Annual Report, 1982

Chemotherapy admissions for gynecologic malignancies have dramatically increased with the introduction of sophisticated and more toxic chemotherapy regimes. Hospital admissions for more sophisticated and efficacious chemotherapy at the Women's Hospital alone have progressively increased from 1979 to 1983 (350,342,383,409, 514)**, putting additional strain on beds and personnel Where possible and desirable, outreach facilities are used but in spite of these facilities and increased usage of them, numbers still would seem to be increasing.

II. Within the next decade, new advances in both the diagnosis and treatment of gynecologic malignancies will come to the fore and hopefully will not only increase early detection and treatment but lower the incidence of gynecological malignancies.

1. Ovarian Carcinoma

a) Serum testing for ovarian carcinoma, i.e. OC 125. The detection of ovarian carcinoma serum antigens is at present being developed with early limited success.

b) Routine pelvic ultrasound screening of females over 50. Pilot projects have met with some success and hopefully a similar project will be initiated soon in Manitoba.

c) Outpatient chemotherapy regimes with less toxic drugs than currently in use.

d) More aggressive initial surgical exploration and debulking of those tumors prior to the initiation of chemotherapy.

+ Source - Manitoba Health Services Commission

** Source - Medical Records, Health Sciences Centre

2. Endometrial Carcinoma

a) Increasing emphasis on endometrial routine sampling as an office procedure to diagnose precursor hyperplasia in high risk populations and estrogen users.

b) More judicious use of post menopausal estrogens combined with progesterone to decrease the incidence of endometrial carcinoma in this high risk population.

c) Educational programs (i.e. fatty diets, obesity, diabetes, etc.) to decrease the overall incidence of endometrial carcinoma.

3. Cervix

a) Increased screening of risk population with Pap smears.

b) Wide acceptance of Pap smear screening with early colposcopy and treatment based on any abnormality found at the time of a Pap smear. A greater emphasis on office treatment with laser and cryotherapy should, hopefully, decrease the need for hospital admission and hysterectomy in the future. The need for more colposcopy facilities is acute and needs to be developed fully if these aims are to be achieved.

c) Provincial registry for Pap smears, as recommended by the Walton Report, is needed. Efficiency and quality control are not optimal unless greater than 25,000 smears are read annually by a lab. At present, only one lab in Manitoba is reading over 25,000 smears* (Table I). Consolidation of these labs is needed to increase quality control and to enable a central registry to develop for diagnosis and results of abnormal smears. Inherent and necessary for the system would be regional or centralized colposcopy services provided by trained personnel.

d) Education regarding venereal transmission and treatment of transmittable infections, i.e. herpes type II, human papilloma virus, etc.

III. Forecasting needs and trends over the next 10 - 20 years is difficult, but these may be generally stated:

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* Source - Manitoba Health Services Commission

a) Patient education regarding the signs and symptoms of gynecological malignancies as well as risk factors leading to these malignancies,(i.e. estrogen, promiscuity, etc.)

b) Earlier identification of gynecological malignancies in ovarian ultrasound screening, higher endometrial office sampling of high risk populations, ovarian carcinoma serum antigens and a concentrated Pap smear program for the high risk population.

c) Centralized reporting and treatment centres for abnormal Pap smears along with centralized high volume cytology labs to lower false negative Pap smears.

d) There is a need for concentration of facilities and manpower in tertiary centres to contend with chemotherapy, radiotherapy and radical surgery involved in these malignancies which will increase as the population ages. The extension of present services and facilities beyond the tertiary care hospitals with a dilution of expertise and the addition of expensive equipment is not cost effective. An upgrading and concentration of facilities and manpower will certainly be needed if present services and, better treatment is to be achieved.

e) Gynecological malignancies require the expertise of radiotherapists probably more than any other group of malignancies. Manitoba is experiencing a shortage of radiotherapists to a greater degree than most of the rest of Canada. Manpower predictions based on current patient loads dictate the need for nine radiotherapists. The need to attract and hopefully train radiotherapists in Manitoba is acute and must be addressed as soon as possible.

NUMBER OF PAP SMEARS READ BY PRIVATE LABORATORIES

Name of Laboratory	1980/81	1981/82	1982/83	1983/84
St. Boniface	4,224	4,589	4,328	4,835
Mall Medical Group	5,289	4,864	4,715	4,861
Provencher	22,490	22,810	23,965	21,833
Assiniboine	15,633	18,650	20,806	23,098
Central Medical	13,223	12,220	11,028	10,393
Trainor Winnipeg	25,344	26,282	26,574	21,821
Totals	86,203	89,415	91,416	86,841

NUMBER OF PAP SMEARS READ IN HOSPITALS IN 1983/84

Concordia	37
Grace	45
Health Sciences Centre	88,603
Misericordia	128
Seven Oaks	642
St. Boniface	2,947
Victoria	49
Westman Laboratory	10,646
Total	103,097

VII OUTREACH

The goals of the Outreach Program are:

1. To enable patients living at a distance from the urban centres to receive ongoing cancer chemotherapy and follow-up in communities close to home.
2. To increase the community based level of cancer knowledge and care.
3. To rationalize cancer treatment costs through better utilization of tertiary beds and equipment.
4. To establish an analyzable province wide management data base in keeping with clinical trials goals and provincial health policy goals.
5. To expand the treatment and research base and thus allow promising investigational treatments to be more easily available to patients not accessible to city centres.
6. To provide province wide cancer treatment quality care assurance.
7. Outreach within the urban environment would include community hospitals and clinics with at least one specialist in oncology on site to provide primary management without radiotherapy or investigational drugs. Each oncologist should also have a tertiary care hospital appointment permitting them to treat patients with investigational drugs or those treatments requiring more intensive care available in the dedicated units.

This proposal for province wide expansion of the existing Outreach Program has been forwarded to MHSC and is contained within a document submitted by Dr. H. Schipper dated February 23, 1984.

VIII MEDICAL PHYSICS

The scope of medical physics support to oncology that is required during the next few years is very dependent on the number of radiotherapists who will be on staff, and their attitudes towards the benefits to be obtained by a comprehensive medical physics service. The Department of Radiotherapy is being restructured at this time, and every indication points to the introduction of a greatly enhanced radiotherapy program, both in scope and in approach. The following comments are made on the assumption that the Department of Radiotherapy will, in fact, take on the role of an active academic department, in which state of-the-art clinical procedures will be accompanied by academic teaching and research activities, as befits a major Cancer Foundation. Consequently the role of Medical Physics will have to expand in order to provide the necessary support in such areas as equipment, dosimetry, treatment planning and follow-up simulation, mold room, hyperthermia, electronic and mechanical services, instrumentation, data processing, developmental projects and research.

Equipment

We can expect to see two therapy units retired during the next few years: the Cobalt F and the SHM 4 MV linac. At least one high energy unit and one low/medium energy unit will be installed.

A simulator will need to be installed at St. Boniface Hospital, as well as a computer terminal for treatment planning. The present planning computer will have to be upgraded for increased speed and for effective utilization of CT scans. It is quite probable that a brachytherapy afterloading system will be required.

Planning Procedures

The trend towards more sophisticated planning will continue. Heterogeneous computations, non-coplanar beams, three-dimensional planning, improved tissue compensation, planning for electron and mixed beams, improved fractionation routines, and more aggressive in-treatment dosimetry. It is to be expected that a much higher percentage of the patients will be referred to Medical Physics for planning, so that there will be a very significant increase in both the number of plans required as well as their complexity.

Simulation Procedures

Most of the Patients treated at St. Boniface Hospital will probably be simulated there, and up to 1000 simulations per year can be expected in this clinic. Together with the use of CT scanning and radical therapy using the Cobalt unit, medical physics involvement at St. Boniface will become much larger during the next few years. The double simulator suite at MCF will continue to be heavily used, and the load will certainly increase as more re-simulation during treatment is requested. It is to be expected that all three simulators will be fully utilized within a relatively short time.

Development

Major areas of development will include electron dosimetry, heterogeneous and 3-D planning, plan quantification for objective assessment, improved port film techniques, computerized treatment recording and verification, determination of specific tissue response and quantitative prediction of complications. An active program in hyperthermia will also be carried out, both at the clinical level and in the laboratory.

Personnel

According to standards approved by the National Cancer Institute, the minimum complement of clinical medical physics staff for 1500 new patients per year is 4 physicists, 5 planning technologists and/or dosimetrists and 2 technologists per simulator.

Taking into account the difficulties associated with operating two facilities (MCTRF and SBGH), the replacement of much old equipment and the increasing complexity of planning procedures, it is possible to estimate the minimum staff requirements during the next few years, and compare it to present staffing levels. The NCI recommendation does not take into account tasks such as teaching, development, special procedures (including CT, port films, treatment set-ups) and other duties such as x-ray film copying, documentation etc. Since our mold room technologists also act as brachytherapy technologists, these categories are grouped together for the purpose of staff complement comparisons. Technical services will have to be expanded to provide the required increased support for clinical oncology. One technologist will be required if a used simulator will be reconstructed and installed at SBGH, and this position will then need to be continued on a permanent basis due to the expected increase in workload. Servicing an extra simulator, one extra linac and a second computer will require an increase of 0.5-1.0 FTE electronic technologist positions. A new position is also required for a electronic design engineer. We have supported such an individual for three years on research funds, and it is now clear that modern medical physics requires full-time engineering support for the design and implementation of digital electronics and microprocessor techniques. The proposed staffing levels are shown in the Table:

	Present (1984)	(FTE)	Required (1985 - 90)
Medical physicist	3		4
Dosimetrist	1		1.5
Computer programmer	0		0.5
Electronic engineer	0		1
Planning technologists	3		5
Simulator technologists	3		6
Brachytherapy/mold room	2		3
Mechanical/electronic technologist*	4		5
Clerical	1		2

(*estimated FTE involved only in oncology support)

IX NURSING SERVICES

Recognition of cancer as a major health care problem has led to the development of oncology nursing as a specialized area of nursing practice. As in all specialties, there is a definite body of knowledge and understanding that must be acquired by the professional nurse in order to deliver this specialized care. The scope of oncology nursing practice includes: clinical practice, education, administration and research.

The role of nursing in the field of Oncology in the Province of Manitoba is not presently well delineated. This makes the forecasting of nursing requirements for optimal patient care difficult. There is currently no predictor of patient requirement for nursing care time, which accurately defines staffing requirements. There is no patient classification tool that relates specifically to an ambulatory care or in-patient setting. Two oncology clinics in Canada are currently addressing this issue, the CCA BC (Cancer Control Agency of British Columbia) and the Cross Cancer Institute of Alberta.

The Manitoba Cancer Treatment and Research Foundation, as the primary cancer care agency in the Province of Manitoba, along with its responsibilities in patient care, education and research, should provide the leadership and expertise in the development of nursing practices in the areas of clinical care, nursing administration, education and nursing research. The team concept of delivering medical services, both preventive and therapeutic, should be furnished by an organized group of physicians, nurses, pharmacists, nutritionists, home care and other health care providers. Complete oncology services to home, community and hospitals could most easily be organized around this focus.

The Immediate and Projected Needs for Oncology Nursing Services in the Province of Manitoba

1. CLINICAL PRACTICE

1. The development of standards for the specialty of general and oncology nursing. Specialty areas in gynecology, pediatrics, medical, surgical and radiation oncology, chemotherapy and clinical trials.
2. Policies and procedures should be developed to describe nursing practices and these should be recorded and readily accessible to staff.
3. A nursing data base should be developed and utilized in patient assessment.
4. The examination of ambulatory care, in-patient care, home and

community care, palliative care facilities, hospice and rural care from the standpoint of the most efficient utilization of nursing in these settings.

5. An increasing role for nurses in symptom management with significant shortening of the length of hospital stay.

6. Legal and ethical issues must also be examined from a nursing perspective.

7. Patient and family education and support systems utilizing social services, physiotherapy, occupational therapy and nutritional therapy need to be developed.

8. Public education with a view to prevention, early detection and increased community awareness.

9. More efficient utilization of nursing services in the in-patient setting with the development of dedicated oncology wards in a tertiary care setting. This will make it possible for specially trained nurses to provide:

- intensive chemotherapy as given by trained oncology nurse specialists
- increased cost effectiveness by pooling resources in one geographic area
- optimal ward care
- symptom control management
- an interdisciplinary team care approach throughout the hospital stay and into the home environment
- attraction of competent staff recruits
- staff emotional support in areas with high staff "burn out"
- for development of technical skills to keep abreast of new techniques and advances for teaching skills to family members in the hospital setting in preparing for earlier discharge
- collaboration and cooperation with other disciplines
- emphasis on rehabilitation
- better cooperation between in-patient and out-patient oncology

ADMINISTRATION

The establishment of standards, policies and procedures for safe and effective oncology nursing practice.

Quality assurance mechanisms to evaluate standards of care.

Job descriptions to clearly outline the nurses' areas of responsibility in patient care.

Performance evaluations and review of nursing practices.

Methods of determining nursing workload.

EDUCATION

Development of an instructional program for nurses administering chemotherapy.

A continuing oncology education program.

A post-graduate program in oncology in line with the recent developments of the CNA (Canadian National Association) relating to nursing certification and specialization.

Nursing adjunct appointments between the University of Manitoba School of Nursing and the Manitoba Cancer Treatment and Research Foundation.

X SOCIAL WORK SERVICES

Oncology Social Work is a developing subspeciality. Few medical settings across the country have an Oncology Social Work section within their Department of Social Work. However, services such as transportation and housing have always been available to cancer patients. These services have often been provided by disciplines other than Social Work.

The importance of this area is apparent as:

1. Cancer patients and their families are seeking counselling services.
2. Medical and other health professionals recognize and accept the important role that social workers play in the multidisciplinary team.

Present Service Delivery

1. Rural Areas

   There are no separate services provided to cancer patients in the rural areas except for the services available through the Canadian Cancer Society. Rural patients have the added problems of being away from home and of having to adjust to a strange city setting. Therefore, a referral to Oncology Social Work is welcomed by these patients. Contacts with them are usually in response to a crisis or are in the nature of short term intensive counselling.

   For a few years, an excellent referral system was established between Oncology Social Work at the Manitoba Cancer Foundation and the Department of Social Work at the Brandon General Hospital. Unfortunately, this referral system has become temporarily non-operational due to staff changes in Brandon. As far as other smaller rural areas are concerned, referrals to Social Work Services are made through the local offices of the Provincial Department of Health and Community Services.

2. All hospitals in Winnipeg have Departments of Social Work whose social workers respond to referrals for services to cancer patients. With the exception of Health Sciences Centre and the St. Boniface Hospital, the other Winnipeg hospitals all have a designated social worker assigned to provide social work services to the cancer patients.

   The structure of the program for cancer patients at the Health Sciences Centre and the Manitoba Cancer Treatment and Research Foundation is complex.

Pediatric oncology, including M.C.F. Pediatric Outpatients, is serviced by the social work staff of the Children's Hospital. Adult oncology has been serviced by four separate social work units, each accountable to a different senior staff member. In addition the Department of Oncology Social Work is budgetted through the Manitoba Cancer Foundation, except the Director's basic salary, while the other social workers having responsibilities for service to Oncology patients are budgetted through the Department of Social Work at the Health Sciences Centre. Both departments are funded by the M.H.S.C.

The four separate social work units serving adult oncology patients are as follows:

a) M.C.F. outpatients and a selected group of Health Sciences Centre inpatients are serviced by the Oncology Social Work Department at the Manitoba Cancer Treatment and Research Foundation. (1.5 E.F.T. Social Workers).

b) General Centre Inpatients (those not covered by the Oncology Social Workers) are serviced by the Surgery-Medicine Social Workers assigned to the designated wards.

c) Respiratory Centre - Social work services to these patients are provided by social workers from the respiratory centre.

d) Gynecology-Oncology Inpatients - A social worker from women's hospital provides services to these patients unless they are previously known to Oncology Social Work at the Manitoba Cancer Foundation.

Gynecology-Oncology Outpatients - Referrals for services are handled by Oncology Social Work at the Manitoba Cancer Foundation unless these patients were previously known to the Social Worker at the Women's Hospital.

Recommendations

1. Oncology Social Work programs at the Health Sciences Centre and Manitoba Cancer Foundation should be coordinated. This would maximize effective and efficient use of professional staff. It will also provide continuity of care between inpatients and outpatients. More importantly, it will allow more flexibility in program planning and staff development.
2. Oncology social work staffing at the Manitoba Cancer Foundation and Health

Sciences Centre has been inadequate in proportion to the number of cancer patients needing social work services. It is imperative that action be taken to correct this situation.

3. Urban-Rural Communication - there should be more formal and regular communication between the Provincial Department of Health and Community Services offices in the rural areas and the treatment centres in Winnipeg.
4. There is an urgent need for a Palliative Care Unit at the Health Sciences Centre. The present system of referring and transferring our terminally ill patients to the Princess Elizabeth Hospital is far from ideal. It is always to difficult and painful to witness the transfers of these patients whose support systems have to be totally interrupted during this very critical period in their lives when psychosocial support is so very crucial to the quality of life of their last years and months.

XI VOLUNTEER SERVICES

Volunteers represent the "spirit of the community"; individuals reaching out to other individuals in need. Volunteers bring another perspective and enthusiasm to an organization. They can complement the professional services by providing more personal attention to patients therefore enhancing the environment and experience for patients in the hospital/clinical setting. Volunteers are "ambassadors" of an organization, that is, they are public relations personnel in building a better understanding between the hospital and the community. All these factors are especially pertinent to a cancer centre where the patients have such special needs.

A Volunteer Services department is the vehicle through which individuals may become volunteers suitable for a given setting.

- The purpose of Volunteer Services at a cancer centre is to enhance patient care and complement professional services.
- Volunteer Services may be under the direct administration of a hospital and/or may be operated in conjunction with an interested organization such as the Canadian Cancer Society, Junior League or service groups.
- Volunteer Services for cancer patients would vary from centre to centre depending on a number of factors including:
  - size of centre,
  - type of centre: inpatient and/or outpatient,
  - assessed needs of patients and families,
  - history of centre and status in community,
  - attitudes and support of centre's administration and staff to volunteers,
  - size of area served,
  - finances/budget,
  - union considerations,
  - attitudes and support of patients served,
  - other available social and support services in hospital and community and relationships thereof, and
  - community to draw for volunteers ie. rural vs urban base; cultural influences; socio/economic influences, etc.
- A needs assessment for each cancer centre would produce the necessary information to develop volunteer programs for that centre.
- The volunteer programs reviewed here are currently in operation at the Manitoba Cancer Foundation, or are successfully running elsewhere in Winnipeg, Manitoba

or Canada. Furthermore, the potential of volunteer programs for cancer patients is as great as the needs perceived and the ability to meet these needs.

VOLUNTEER PROGRAMS AT THE MANITOBA CANCER FOUNDATION

1. Escort Service - accompany patients and families wherever needed in the facility; transport articles pertaining to patients (charts, specimens, etc.) from area to area as needed.
2. Information/Reception Service - provide public relations role in greeting and directing people; possibly answer telephone, relaying messages to staff and patients.
3. New Patient Orientation - provide extra needed attention to new patients to become familiar with setting and feel more at ease. In other hospitals the titles may be varied, eg: a) Admitting Assistance, b) Patient Welcome Committee and c) Registration Escort.
4. Host/ess Service - receive patients in clinic and treatment areas; provide information (eg. about simulator); help with preparatory routines (eg. weigh-in).
5. Nurses Assistants - change linens; prepare examining rooms; tidy treatment areas; stock supplies; plant care and so on.
6. Clerical Supports - assist office management and clerical duties eg. write receipts and thank you cards for donations, photocopying, filing and so on.
7. Library Cart/Patient Library - make available books and magazines; as an outpatient centre, specific cancer literature is only required however inpatient centres also need general reading material.
8. Family Relief Service - volunteers assist the family by babysitting child with cancer, babysit siblings, or general babysitting to free parents; sit with adults with cancer to relieve family members.
9. Play Aids - assist in Children's clinics and general playtime.
10. Centre Newsletter - facilitate its production; promotes public relations among areas.
11. Special Projects - prepare Christmas and Easter projects, ie. hampers, gifts, decorations, etc., wash toys; prepare gifts (Sunshine Baskets) for patients; substitute for staff on vacation; assist staff programs ie. United Way Campaign,

CPR Training; and so on.

12. Volunteer Drivers - transport patients to and from centre for treatments.

13. Hostess Cart - offer beverages free of charge to patients (outpatient area).

14. Wig Service- provide headwear to patients.

15. Lodging - lodging facilities eg. Lennox Bell Lodge and Ronald McDonald House require volunteers to man facility as managers, coordinators, or host/esses and to offer a variety of programs eg. Recreation programs. Volunteer Services liases with these facilities and provides assistance when requested. Specifically, the M.C.F. Volunteer Services has been requested to be a resource in implementing a volunteer program at Ronald McDonald House.

16. Patient-Family Learning Centre - develop and/or organize brochures and other printed information on cancer; develop and coordinate slide-tape presentations, cassettes and videos on various topics and make these available to patients and families.

17. Support Services - i.e. Self-Help Groups: volunteers and patients establish interpersonal relationships to share information, concerns, Mastectomy Visitation Program, CanSurmount Program, New Voice Club, Ostomy Association, Vulvectomy Visitation Program, Family Support Group, parents groups and daily support as telephone calls to check up on patients and answer routine questions.

The remainder of the programs are operating in other centres.

1. Pastoral Service - volunteers recruited via churches and synagogues to be available onsite or as oncall visits, hospitals may have formal religious services with professional and volunteer staff.

2. Aide for Occupational Therapy - carry out individualized treatment program for patients.

3. Aide in Physiotherapy - carry out individualized treatment programs for patients.

4. Aide in Recreation Therapy - do bedside activities, do individual or group activities - Music Therapy, Art Therapy and Play Therapy; coordinate or assist in Crafts, Films,Teas, Outings, Bingos, Games, Entertainment and Special Events.

5. Coffee Shop - offer lunch hour service to patients and families who are delayed by morning appointments.

6. Hairdressing/Barber Services - mostly for inpatient centres and long term care facilities.

7. Shopping Cart - provide small items for inpatients to purchase eg. toiletries, magazines, etc.
8. Flower Delivery - for inpatient centre only.
9. Mail Delivery - sort and deliver mail, especially for inpatient centres and long term care facilities.
10. Menu Selection - for inpatient centre, volunteers help patients - this is a vehicle for visiting.
11. Tour Guides - conduct public tours in centre.
12. Home Care Services - volunteers may supplement this service in varying ways (depending on community resources) eg: home visits, meals, etc.
13. Shuttle Bus Service - transport patients between centres ie: between different needed buildings; or between treatment centre and hospital lodging.
14. Fundraising - various projects as needed and must be carefully scrutinized. eg: Any Manitoba Hospital which has a Guild.
15. Archives/Historical Service - investigate and maintain records.

There are a variety of ways volunteers can contribute to the well-being and health care program of patients. The cancer patients at the Cancer Foundation have benefited greatly by the volunteer programs. Volunteer Services at the Foundation has been instrumental in realizing these programs for patients. While it is difficult to quantify, if one would speculate a salary for the time offered freely by volunteers and then multiply that by the hours worked, one would be surprised by the five digit figure which results. For example, at the Foundation, eighty-two (82) on-site volunteers (ie. not drivers) gave over 3,300 hours from January to August, 1984, at $7.00/hour**, $23,000 worth of services has been gained at minimal cost. However, an alternative way of considering this is that the cost of one person's salary plus operating expenses produces additional manpower of 82 and about seventeen (17) varied services directed to enhancing patient care. Furthermore, the volunteer programs supplement the staff in the performance of non-professional duties thereby freeing them of those tasks impinging on their time.

Volunteers provide a valuable service to the patients and staff of the Manitoba Cancer Foundation and could be expanded to meet the needs of similar patients elsewhere in the province.

** Figure derived on factors of skills and experience volunteers bring to the job.

OUTPATIENTS SUBCOMMITTEE REPORT

INTRODUCTION

With the aging population, the current constraints on the economy, and the rising demands for health care services in the face of limited health care resources, more efficient and effective methods of health care delivery must be developed in the Province of Manitoba. It has long been recognized that admissions to acute care hospitals are the single most costly component of the health care system, accounting for approximately 60% of all government expenditures on health care services (1,2). Health care planners therefore have recommended repeatedly the development of more ambulatory or outpatient services as a means of controlling the increasing cost of health care (3-6).

In June 1984 the Minister of Health, the Honorable Mr. Larry Desjardins, established a number of subcommittees under the auspices of the newly formed Health Services Review Committee, to examine more thoroughly this dilemma currently facing the province's health care system. The subcommittees were specifically directed to assess:

1) - the types of diseases and patient care which continue to require traditional hospitalization, and the anticipated trends in these areas

2) - the types of disease and patient care problems for which alternatives to traditional hospitalization could be developed, the resources needed to implement these changes, and the impact of the changes on the quality of health care.

3) - the potential savings to the health care system from developing alternatives to traditional hospitalization.

The subcommittee were requested to focus particular attention on the needs of the growing population of elderly in the province.

The Out-patients Subcommittee:

Outpatient or ambulatory care services encompass a wide variety of different types of patient care including:

a) Hospital-based services
  - Emergency Departments
  - Outpatient Clinics
  - Dialysis Units
  - Day Hospitals
  - NFA Surgery

b) Community-based Services
  - Physician's Offices
  - Community-based Clinics
  - Community-based Hospitals
  - Community-based Services

In view of the other sub-committees established under the Health Services Review Committee i.e. the Community Health Services; Elderly; NFA Surgery; and Injuries and Poisoning Sub-committee, the Outpatients Sub-committee limited its attention to two specific types of outpatient or ambulatory care, specifically:

a) - Hospital-based Outpatient Clinics

b) - Community-based Primary Care Clinics

As instructed, the Committee paid specific attention to the role of these two types of ambulatory care in meeting the needs of the growing elderly population in Manitoba. The Outpatients Sub-committee was composed of the following individuals:

C. Murphy, M.D., Chairperson
St. Boniface Family Medical Centre

W. Coke, M.D.
Ambulatory Care, Health Sciences Centre

G. Coyston, B.A.
Lay Representative

I. Elliott, M.B. Ch.B.
Virden Medical Associates

V. Holsteen, R.N., M.S.N.
Ambulatory Care, Health Sciences Centre

P. Mirwaldt, M.D.
St. Boniface Family Medical Centre

H. Payne, R.N., Recording Secretary
Manitoba Health Services Commission

R. Tamblyn, R.N., M.Sc.
Health Services Review Committee

BACKGROUND INFORMATION:

A. Hospital-based Outpatient Clinics

1. Historical Perspective

Hospital-based outpatient clinics in North America, like their predecessors in Europe and the United Kingdom, were originally established to provide free or low cost health care services to the poor (7-9). Hospitals provided the necessary facilities and support staff. Physicians donated their time and services free of charge. As a result the clinics were often organized and operated more to meet the requirements and preferences of the health care providers, than to meet the needs of the patients. Nevertheless, outpatient clinics did provide valuable services otherwise unavailable to many groups of society.

The training of medical students, interns and residents later became a major function of outpatient clinics based in teaching hospitals. In fact the Royal College of Physicians and Surgeons has specifically stated that all residents must receive supervised training and experience in providing patient care services in an ambulatory or outpatient setting, in order for graduate training programs in medicine and surgery to receive full accreditation (10-11). As a result outpatient departments based in teaching hospitals continue to grow and develop despite the introduction of Medicare in Canada in the 1960's, which technically eliminated the economic need for hospital supported clinics. Universal comprehensive health care insurance nevertheless had a major impact on the operation of the clinics. Consumer demands and expectations for health care services have been growing steadily in recent years throughout North America (12). With the introduction of medicare, patients attending outpatient clinics began to expect the same high quality of care, facilities, and service previously only available in private physicians' offices. At the same time, physicians working in the clinics began to expect adequate remuneration for their time and services.

More recent changes in health care and the health care system have altered the role of hospital-based outpatient clinics even more profoundly. With the rapid growth in medical knowledge in the past two decades, increasing numbers of physicians have found they must specialize or subspecialize, in order to maintain high levels of expertise in some aspect of health care (13-16). Physicians simultaneously have become increasingly dependent on new forms of medical technology to diagnose and treat many types of disease. Ready access to sophisticated, often extremely costly, equipment, support services and support personnel, is only possible in large institutions like hospitals (14,16,17). As a result more and more physicians, particularly highly trained specialists, now find they must practice in a hospital setting in order to provide the kinds of health care services they have been trained to provide. At the same time, hospital-based outpatient clinics have become the only ready means of access to many types of health care services, equipment, and personnel, without resorting to admission to hospital. In response to these same trends, community and rural hospitals now face growing pressure to provide greater outpatient services. In the absence of more appropriate facilities, physicians working in community and rural hospitals often are obliged to use Emergency Room space, equipment, and support personnel, in order to provide elective ambulatory care services.

Finally, outpatient departments based in teaching hospitals have become increasingly important in the last few years, as a source of revenue for Faculties of Medicine. Under the current Geographical Full-time Agreement, no full time physician with the University of Manitoba's Faculty of Medicine may establish an office outside of the teaching hospitals, for the purpose of developing a private practice (18). As resources for medical education and research have become progressively scarce, faculty members face growing pressure to generate a greater proportion of their incomes by providing patient care services (19,20). In turn outpatient clinics, based in teaching hospitals now face growing pressure to function more efficiently, eliminate unnecessary operating expenses, and allow faculty members to generate sufficient revenue to maintain their incomes at a level comparable to other physicians practising in the surrounding community.

2. Structure and Organization of Hospital-based Outpatient Clinics.

The administrative structure and organization of hospital-based outpatient clinics have tended to parallel and reflect their historical evolution (21,22). Most outpatient departments based in Canadian teaching hospitals are still divided by Clinical Departments, like the corresponding medical training programs. Physicians working the clinics are responsible primarily to their Clinical Department Heads for the health care services and teaching they provide. Nurses and other support staff working in the same area, generally are responsible primarily to the hospital administrations which employ them. As a result, traditional hospital-based outpatient clinics lack a single administrative organization with overall authority and responsibility for the health care services provided. The lack of an integrated administrative structure in turn tends to result in lower standards of patient care, poor services and inefficient use of resources (21,22). Despite their growing importance in the health care system, hospital-based outpatient clinics are widely perceived to be costly and inefficient. This perception is reinforced by a number of other factors:

1) - many hospitals assign inappropriate, extraneous expenditures to the budgets of their Outpatient Departments inflating the apparent costs (23,24).

2) - hospital-based outpatient clinics, particularly medical clinics based in core area hospitals, tend to look after patients who are older, have more severe medical problems, come from lower socioeconomic backgrounds, and have more communication problems than patients seen in private clinics and physician's offices (25,28). Costs therefore tend to be higher in comparison.

3) - the heavy commitment of outpatient clinics in teaching hospitals to medical education tends to reduce efficiency [illegible] increase costs (29).

If outpatient clinics are to be developed and expanded as a means to control the rising cost of health care services, new and more effective methods of organizing and administrating outpatient departments must be developed and implemented at the same time. Outpatient clinics must be provided with adequate facilities and funding, but must also be held accountable for their expenditures and operating costs. Finally, outpatient departments involved in teaching programs should be compensated for the additional costs incurred as a result of educational, rather than patient care activities.

3. Potential Cost Savings Through Expanded Hospital-based Outpatient Services:

Hospital-based outpatient clinics potentially could reduce hospital admissions through three basic mechanisms:

a) by providing diagnostic and therapeutic services that currently require admission to hospital

Outpatient (NFA) surgery programs have clearly shown substantial reductions in hospital admissions, and in turn have successfully reduced the cost of health care services. Hospital-based outpatient clinics similarly should be able to eliminate or to reduce substantially hospital admissions for medical investigations. Moreover, a number of ambulatory or outpatient treatment programs have already been developed in Manitoba and elsewhere, reducing the need to hospitalize patients for certain types of medical care.

These programs include:

- dialysis programs
- chemotherapy programs
- outpatient intravenous antibiotics programs
- ambulatory TPN programs
- high risk prenatal care programs

- day hospitals for:
    - new cases of insulin dependent diabetes
    - geriatric patients
    - rheumatologic disease
    - chronic respiratory disease
    - palliative care

Estimating the potential cost savings from substituting outpatient for impatient health care services however, is an extremely difficult process. Accurate statistics on the type of patient care problems currently leading to hospitalizations must be developed first. From these statistics, the number and types of patients who could be treated effectively in an ambulatory or outpatient setting could be determined and the potential cost savings established. The statistics currently available through the MHSC, designed primarily to provide payment for insured services, are not adequate for this purpose.

Even with complete and accurate statistics, estimating the potential savings to the health care system will still be extremely difficult. Many health care planners cite the experience of Health Maintenance Organizations (HMO's) as an indication of the potential savings that could be achieved from substituting outpatient for inpatient services (30). HMO's in the United States and Canada clearly have succeeded in reducing the cost or health care services for their members by 10% to 40%, primarily through reductions in the use or hospital services by 24% to 62% (31-34). A close examination of HMO's reveals however that their members make approximately the same number of outpatient visits to physicians, as do patients with other forms of health care insurance (31). Average durations of stay for patients hospitalized under HMO plans, are not significantly shorter (31). The saving achieved by HMO's therefore appear to result primarily from reduced rates of hospital admissions, and not from the substitution of outpatient for inpatient services. The reasons for the lower rates of hospitalization have not been clearly established. Fewer admissions may result from different methods of physician payment employed by HMO's which eliminate incentives to admit patients (31), from better integration and administration of health care facilities and services (35), or both.

A review of 134 papers in the recent medical literature directly examining the cost savings from substituting outpatient for inpatient services, revealed only four studies with substantial data. Only two of the four studies suggested substantial savings could be achieved (36). As in the literature on HMO's, a key factor in cost reduction as the establishment of health care delivery systems where outpatient, inpatient and community support services were well integrated, coordinated and effectively administered, and not simply the substitution outpatient for inpatient health care services (37).

b) by providing ongoing health care services for patients with chronic medical problems

As stated previously medical outpatient clinics in hospitals in both the United States and Canada tend to look after patients who are older, have more severe, often multiple chronic medical problems, come from lower socioeconomic backgrounds, and have more problems with communication than patients seen in private practice (25-28). With ready access to hospital resources, outpatient departments can provide this small but growing population of patients with a number of diagnostic, therapeutic, and support services, not easily duplicated in the community. By providing more comprehensive ambulatory services, outpatient departments should be able to reduce the frequency of acute exacerbations and complications in these patients, and in turn reduce the frequency with which they require admission to hospital.

c) by shortening the average duration of stay of patients requiring hospitalization

With ready access to the hospital's diagnostic and therapeutic services, outpatient departments should be able to reduce significantly the average duration of stay of patients requiring admission. Hospital stays can be shortened through a variety of services including:

- pre-operative evaluation and treatment of patients requiring surgery
- post-operative care and supervision, allowing earlier discharge from hospital following surgery
- ongoing provision of medical treatment initiated in hospital, allowing earlier discharge of medical patients
- outpatient rehabilitation programs

Whatever the mechanism to reduce inpatient hospital services, maximal cost savings can only be achieved through effective integration and coordination of inpatient, outpatient, and community health care services. Moreover, regardless or the mechanism of cost reduction, the savings achieved by the health care system through increased use of outpatient services, will be extremely difficult to determine.

4. Hospital-based outpatient clinics in the 1980's and beyond.

The role of hospital-based outpatient clinics has changed dramatically since their original inception as hospital sponsored charitable services for the poor. New and growing demands already are being placed on outpatient departments both in terms of patient care services and in the area of medical education, at a time when both health care and education resources are becoming progressively scarce. If outpatient departments are to respond successfully to these new challenges, dramatic changes must also be implemented in the traditional structure, organization and administration of the clinics.

a) patient care services

To alleviate the growing pressure on acute care hospital beds, outpatient departments must provide at least two distinct types of patient care services. First they must be able to provide fast, efficient and extensive diagnostic and therapeutic services to patients referred from the community, scheduled for admission to hospital, or discharged from hospital. Second, they must be able to provide comprehensive, ongoing health care services to the small but growing group of patients with severe chronic medical problems, who cannot be managed adequately in the community. In order to provide these kinds of services, outpatient clinics must have ready access to the hospital's sophisticated equipment, services and support personnel. This ready access can be achieved in a number of ways:

- hospitals can establish efficient scheduling and transport systems, giving outpatients ready access to inpatient facilities and services.

- hospitals can duplicate the necessary equipment, support services and personnel, giving the outpatient departments their own resources.

- the appropriate diagnostic and therapeutic services for the entire hospital can be established within, or adjacent to, the outpatient department. Inpatients requiring access to the resources can then be transported to and from the area.

As health care services provided within the clinics become progressively more complex and comprehensive, outpatient departments must also develop a multi-disciplinary approach to patient care. In order to achieve maximal effectiveness and efficiency, the outpatient department of the future will require the skills and expertise of a variety of health care professionals, specifically trained to function in an ambulatory or outpatient setting. In addition to physicians, these health care professionals include:

nurses -

clinical specialists in nursing to triage and coordinate outpatient appointments, assist with diagnostic procedures and treatment programs, provide patient education, and insure continuity of care with the hospital wards and community services.

allied health care professionals -

including: social workers
pharmacists
dieticians
physiotherapists
occupational therapists
chaplains
etc.

Finally, as outpatient departments become more specialized, more dependent on elaborate diagnostic and therapeutic support services, and adopt a multidisciplinary approach to patient care services, there will be a growing need for highly trained, experienced administrators to plan, coordinate, and supervise the efficient operation of the clinics.

b) education services

In recent years, both the Licentiate Medical Counsel of Canada (responsible for accrediting undergraduate medical teaching programs) and the Royal College of Physicians and Surgeons of Canada (responsible for graduate medical education) have stressed the need to expose medical students, interns and residents to ambulatory care as an integral part of their training. Teaching hospitals therefore must develop well equipped, well organized outpatient departments if their affiliated undergraduate and graduate medical training programs are to remain fully accredited. At the same time future physicians must be exposed to well equipped, well organized outpatient clinics, if they are to be adequately prepared to provide a growing proportion of health care services, on an outpatient rather than an inpatient basis.

During a recent on-site visit, the Accreditation Survey Team from the Royal College of Physicians and Surgeons concluded that the ambulatory care facility within one of Manitoba's major teaching hospitals was grossly inadequate, both in terms of patient care, and for teaching medical students, interns and residents (38). The outpatient facilities of our major teaching hospitals therefore must be upgraded on an urgent basis. As part of this process, these outpatient departments should be developed as model ambulatory care facilities, which could be used in turn:

- to develop, implement and evaluate new types of ambulatory patient care services
- to provide needed training and clinical experience for undergraduate and graduate medical trainees, nurses, allied health care professionals, and hospital administrators

- to evaluate the impact of expanding outpatient health care services, including the potential impact on cost savings

The planning and redevelopment of the outpatient departments within the different teaching hospitals should be carefully coordinated, to avoid unnecessary duplication of facilities and services, and to insure optimal use of resources. Moreover, in view of the growing demands for outpatient services, model outpatient departments should also be developed and carefully evaluated in at least one community hospital, and at least one rural hospital. The knowledge, technical expertise, and practical experience gained from these model outpatient departments, could then be used to plan and implement other outpatient facilities and services throughout the province.

c) organization and administration

Three fundamental observations should be considered when trying to develop more effective administrative structures and organizations for outpatient departments:

a) outpatient departments require a single administrative organization with overall responsibility and authority for patient care services, to insure a high standard of care, efficient service, and effective use of resources (21,22).

b) the health care professionals working within the department must have direct input into the planning and administration of patient care services, to avoid internal conflicts and insure optimal efficiency (39).

c) each outpatient department must have its own cost centre and be held accountable for its own budget, to insure optimal use of resources (21,22).

To meet these requirements, outpatient departments should be organized as separate administrative sections or divisions within their parent hospitals. Each department should have its own budget, for which it is accountable. At the same time the MHSC should consider the type and volume of services provided through the outpatient department, as a separate criterion for determining the global budget for the parent hospital. Finally, the cost effectiveness of existing outpatient departments should be carefully examined before any major building programs are undertaken to develop and expand hospital-based outpatient facilities throughout the province.

A number of other factors must be considered when establishing budget guidelines and administrative structures for outpatient departments in teaching hospitals. Geographical full-time physicians (GFT's) within the Faculty of Medicine must be provided with adequate facilities and support services within the outpatient clinics, in order to establish their clinical practices, as well as fulfill their teaching responsibilities. If appropriate facilities and support services are provided, it is not unreasonable to expect GFT's to return a portion of their fee-generated income, back to the teaching hospital to help offset the cost of operating the clinics. Negotiations involving the teaching hospitals, the MHSC, the Faculty of Medicine, and the GFT physicians, are needed to establish the appropriate proportion of fee income to be designated as overhead expenses.

In turn, if GFT physicians are to be required to pay overhead for the use of outpatient facilities and services, they must also be given a central role in the planning and administration of the outpatient departments.

Finally, in establishing the operating budgets for outpatient departments in teaching hospitals, costs resulting from educational rather than patient care activities, should be identified as a separate item. To insure that the teaching hospitals and the physicians are not penalized for these additional costs, negotiations involving the hospitals, the province, and the various teaching programs which use the outpatient departments, are needed to establish an equitable cost sharing arrangment for educational expenses.

5. Recommendations:

1. The existing outpatient departments in Manitoba's major teaching hospitals should be developed and expanded as model ambulatory care facilities.

2. To accomplish this goal these departments must:

- have ready access to the sophisticated diagnostic and therapeutic equipment, support services, and support personnel within the teaching hospital.
- develop a multidisciplinary approach to patient care.
- insure effective and efficient coordination of patient care services within the outpatient clinics.

- insure continuity and integration of care between the clinics, and inpatient wards, and the health care and support services within the community.

3. As model ambulatory care facilities, outpatient departments in the teaching hospitals should be used:

    - to develop and implement new types of outpatient services.
    - provide teaching and experience for undergraduate and graduate medical trainees, nurses, allied health care professionals, and hospital administrators.
    - evaluate the impact of expanded outpatient services on both the quality and the cost of health care.

4. Model outpatient departments also should be established in at least one community hospital, and at least one rural hospital, in order to evaluate the impact of distance, travel time and coordination of services on costs.

5. The knowledge, technical expertise and practical experience gained from these model outpatient departments should then be used to plan and develop as required additional outpatient facilities and services throughout the province.

6. To promote greater efficiency and more effective use of resources, outpatient departments should be established as a separate administrative division or section within the parent hospitals. The single administrative structure must include direct involvement from the health care professionals working in the area.

7. Outpatient departments should be assigned separate budgets and be held accountable for those budgets.

8. The MHSC should consider the type and volume of outpatient services provided, as a separate criterion in establishing the global budgets for hospitals.

9. New cost sharing arrangements should be established for outpatient departments in teaching hospitals. Negotiations must include representatives from the teaching hospitals, from the Faculty of Medicine, from the MHSC and the the Geographical Full-time Physicians.

10. Educational costs should be identified as a separate item in the budgets of outpatient departments. Cost sharing arrangements for educational activities should be determined separately through negotiations involving the teaching hospitals, the educational programs which use the outpatient facilities, and representatives from the provincial government.

COMMUNITY BASED SERVICES

As an extension of the discussion surrounding outpatient services, the Outpatient Subcommittee agreed to look at the organization of community based ambulatory health care in an effort to identify potential savings in the overall health care expenditure. In Canada (and elsewhere) health care systems have been planned based on the belief that effective primary care would prevent many diseases and subsequently prevent hospital and equipment utilization. To the present time, there is no firm evidence to support this widespread notion. Community-based ambulatory health care can conceivably improve health and save dollars by two routes:

1) prevention of illness (eg. immunization programs, control of hypertension.)
2) maintenance of health (eg: management of diabetes, periodic health examinations) to prevent deterioration and subsequent hospitalization.

The tasks of calculating savings accrued by "preventive health services" is based on so many assumptions that the end figure may not be meaningful. Nonetheless it would seem reasonable to expect that the contribution of ambulatory health care to the overall health care budget could be that of reducing the burden of disease.

In an effort to bring a rational planning process into health care delivery, both the Ontario and Quebec provincial governments commissioned Health Planning Committees(40,41). Each group developed a decentralized system in which the community's needs were considered in planning the health services provided. A decade later these programs are not fully operational. An evaluation of the Quebec plan shows little success in attaining the ultimate goal of improving the health status of their population. Unfortunately, neither province has documented its evaluation procedure or results. Both programs cited financial constraints and resistance to change on the part of organized medicine as stumbling blocks to full success.

In Israel a Community Oriented Primary Care Program was developed as a strategy to improve health outcomes at less cost (42,43,44). The plan utilized epidemiologic and clinical skills in a complementary fashion to tailor a primary care program to the particular health needs of a defined population. Four discrete steps were outlined:

1) to define and characterize the community in question.
2) to identify community health problems.
3) to modify the health program to address priority problems and
4) to monitor the effectiveness of the program and to make modifications.

The plan stressed the use of a pragmatic form of epidemiology to appraise needs and priorities, to make community diagnoses and to perform disease surveillance. Concentration on target groups and the continuous monitoring and evaluation of programs are key elements in the process. This approach sounds practical, unfortunately its success in improving the health status of the Israeli population has not been documented yet. The authors of the plan called for demonstration units to allow implementation of the process in a microcosm so that its benefit could be established.

Most proponents of community based health care systems stress that organized medicine has consistently resisted attempts to implement new community systems of health care organization. Doron stated that education of primary care physicians was the primary source of "indoctrination" for the Israeli system. Continuing medical education was of lesser importance(42).

In Canada, medical education has traditionally taken place in an acute care hospital setting. Ambulatory outpatient departments set in hospitals served as the only example of primary care delivery. The University of Manitoba Faculty of Medicine now provides a six week primary care clerkship which is based in (mostly rural) private practice settings. Except for this experience, medical education is an acute care, high technology approach to health. Recognizing this, the Royal College of Physicians and Surgeons in Canada, the Institute of Medicine in the United States and other licensing and educational authorities now require training in an ambulatory setting as part of their postgraduate programs. In Winnipeg, the Core Area/Health Action Centre Study (1985) reiterated that relevant primary health training cannot appropriately occur entirely within the confines of a tertiary care institution. The study recommended that the university and the Health Action Centre develop a model teaching public health unit(45).

Recent studies have shown only a (30%) compliance rate by practicing physicians with recognized standards on preventive care(46). Battista found that the mode of remuneration was an important motivating factor for prevention. Wilkins and Hoey (1985) also found that physicians lacked the economic incentive to provide health promotion and preventive care services to their patients (47). Their solutions were alternatively:

1) To allow for autonomous but dissociated practise by physicians and nurses; physicians trained in diagnostic and therapeutic modalities and nurses in prevention counselling and long term care.

2) To provide remuneration (and training) to physicians for preventive and counselling services. In Israel the Community Oriented Primary Care Program pointed to the development of expertise in clinical and epidemiologic skills by physicians as a method of bringing preventive health care to the forefront of medical care (48). A commitment to the training of primary care epidemiologists (as could be done in a public health teaching unit in core area Winnipeg) would bring such a focus to Manitoba's health care (45).

During the Outpatient Subcommittee's deliberation, much attention centered on the need for coordination of services in order to streamline the health care system. Lack of communication between hospital, laboratory and community services was cited repeatedly as a costly and inefficient aspect of our present health care system (49). As part of a model out-patient facility, the committee recommends special attention be paid to alternative systems of organization of health care delivery such that the most effective meshing of inpatient, outpatient and community services develop. The services provided by nurses, in the expanded role of health educator and direct provider of services can be modelled from the specialty referral clinics at the Health Sciences Centre. In similar fashion, the appropriate roles for nutritionists, physiotherapists, occupational therapists, social and pastoral care workers, can be worked out in a model ambulatory care clinic.

The Outpatient Subcommittee was unable to obtain specific information regarding diagnostic categories and treatment modalities in order to compare the efficacy of inpatient versus outpatient status. These statistics are simply not kept in Manitoba. As health care moves toward using evaluation as part of planning procedure, usable data banks with specific information must be generated. Another unmet need is for health indices specifically designed to evaluate preventive and health maintenance manoeuvres. Once sensitive instruments are available, the question of the effectiveness or primary care in reducing burden of disease and improving health status can be more clearly answered.

RECOMMENDATIONS:

In summary, the Outpatient Subcommittee considered community based health care services as an essential area of planning and priorization, if health care costs and Manitoba's health status are to be effected. Hospital utilization is effected by what occurs (or does not occur) in the community. The situation is further complicated by the fact that our health service delivery system has more than one goal: health care, education of health care providers and supportive services. Rather than recommending wholesale, unproven changes to the present delivery system, the subcommittee suggests:

1) The provincial health department, in conjunction with the University of Manitoba, should set up a model Community Oriented Primary Care Program. If evaluation proves it to be successful, similar units can be established throughout Manitoba. The Health Action Centre appears to be an ideal urban setting for this model. Because problems of accessibility are particular to rural areas, a similar model should be developed in a rural region.

2) Within the model of Community Oriented Primary Care Program, the problem of coordination of community health and support services and technologic investigations should receive particular attention. The problem is complex and each region may require its own solution.

3) Undergraduate medical education in Manitoba should emphasize the ambulatory setting as the major location for provision of medical care. All health care providers ought to be trained to work cooperatively to treat and maintain patients without hospitalization where possible.

4) The Manitoba Health Department, along with the University of Manitoba Department of Community Medicine should develop the data base necessary to make evaluation a standard part of health care planning. Improved collection and storage of specific utilization data will allow more information to be available to decision makers.

5) The Manitoba Health Department, along with the University of Manitoba Department of Community Medicine should strive to develop and standardize health indicators sensitive enough to elucidate the impact of preventive and counselling services on the health status of Manitobans.

The Elderly and Health Care Utilization

The Minister of Health urged each subcommittee to consider the impact of the increasing proportion of elderly on the health care system in all their deliberations (50). This province is fortunate to have had the Manitoba Longitudinal Study on Aging (Roos Shapiro, 1981) and several follow-up studies completed using the actual Manitoba Health Services Commission utilization data (51,52,53). This exhaustive study uncovers several interesting points about how the elderly in Manitoba use the health care system:

1) less than one-third of the sample made 72% of all ambulatory visits.
2) 10% of the elderly population accounted for 78% of all hospital days.
3) In fact, 41% a sizeable number of the elderly, accounted for only 5.8% of ambulatory visits. Thus, a small proportion of the elderly in Manitoba are high volume hospital users, a pattern similar to other age groups.
4) The elderly have about one-half the consultation rate of the general population.
5) The elderly generally use few of the expensive medical services (Roos, Shapiro, Roos, 1984) similar to findings in the United States.
6) The rural elderly are hospitalized at a rate consistently higher than the

> urban elderly. This may be because of comparative rural poverty, larger travel distances and the Manitoba climate or because of greater availability of hospital beds in rural Manitoba.

Despite the finding that the elderly in general are not high users of health care services, the facts remain that a small group of elderly use a high proportion of days in hospital. Combined with the fact that consultations are made less for this group than the general population, Roos and her co-authors suggested that a more intensive support service and geriatric referral services may impact greatly on the number of hospital days used by the elderly.

In Israel, Michaele and coworkers established hospital-based alternatives to hospitalization (54). Day Care Clinic, where patients came to hospital for diagnostic and therapeutic services and Home Care Clinic where chronically ill patients were managed at home. By comparing one years data with the previous two, the authors estimated a health care dollar saving of 38-69% by use of these two alternatives. Similar programs exist already in Manitoba, eg: St. Boniface Geriatric Day Hospital.

The Task Force on the Allocation of Health Care Resources (1984) pointed to the need to create an overall new program of care for the elderly which emphasizes independent and productive living at home (55,56). The need for community support services was strongly promoted as was wider adoption or palliative care programs. The task force pointed out two problems:

1) A lack of coordinated services (multi-level care facilities) to cover the entire spectrum of needs.

2) The standard of care in many nursing homes was found to be grossly inadequate.

Manitoba is fortunate in already having in place reasonable standards for personal care homes and a Home Care Program on a province wide basis to assess needs for and deliver suupportive services.

RECOMMENDATIONS:

Clearly the impact of the elderly population on health services in Manitoba ought to be to force, a rethinking of how health care is organized and provided in the province. The question as to whether the organization of health care is based best on a community approach or a hospital outreach approach is unsettled. The Out-Patient Subcommittee recognizes that working examples of each type of service are available in this province, and suggests:

1) The Manitoba Health Department should undertake to analyse the proportion of elderly in the province which would require services in the forms already available (community supports, Home Care services, day hospitals, institutional care), and to uncover any unmet needs which may exist among the elderly in the province.

2) Further, the Manitoba Health Department should make a comparison of the costs accrued to the provincial health care budget by alternative types of health service delivery and recommend the most cost effective combination.

3) The Manitoba Health Department should specifically evaluate the unique problems of health care delivery to the elderly in a rural region and take these into consideration when planning provincial programs.

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PEDIATRIC SUBCOMMITTEE REPORT

Health Services Review Committee

Preamble

Following initial contact by Mr. David Pascoe and Brian Gudmonson in June 1984, Dr. V. Chernick agreed to chair this subcommittee which had the following terms of reference:

1. To identify current and new categories of disease/treatment for which there is no alternative to hospitalization. State possible trends in these areas over the next decade based on local experience and literature.

2. To identify current and future categories of disease/treatment for which there are alternatives to traditional hospitalization. To make recommendations as to how a change from in-hospital to out-of-hospital diagnosis/treatment could be brought about. To estimate and comment upon impact in terms of quality of health care for Manitobans.

The membership was approved in principle on August 7, 1984 (Appendix 1). Although he could not attend meetings, Dr. E. Elves, Brandon agreed to act as a corresponding member. The following Committee meetings were held: August 28, 1984, September 25, 1984, October 11, 1984, October 25, 1984 and a final meeting on December 4, 1984 to consider the draft report.

At its initial meeting the committee agreed to the approach of developing a number of hypotheses relating to pediatric services in the Province and to attempt to test each hypothesis with appropriate data before reaching a final recommendation. The commitee took a broader approach than indicated by the terms of reference above and addressed cost efficiencies in general for pediatric health services for the present and future.

This report will enumerate these hypotheses, provide some background data on the body of the report and more complete data in data base appendices, list recommendations agreed upon by the subcommittee and their potential, positive and negative impact where appropriate.

HYPOTHESES

Hypothesis 1: That in the urban Winnipeg area there are too many pediatric beds (excluding newborn infants) and the utilization of these beds is not cost effective.

Data Base: All pediatric admissions by disease category in age groups (excluding newborns) <2 years, 2-12 and 13-16 to each hospital in the province for a 5 year period (1979-1983). The computer print-outs are on file at the MHSC and summarize statistics for urban and rural hospital are provided in Appendix 2. The subcommittee concentrated on admissions to hospital in the urban Winnipeg area (1983-84):

Hospital	Set Up Beds (Excluding Newborns)	Patient Days	% Occupancy
Misericordia	42	6,144	40
Grace	39	2,387	17*
St. Boniface	72	12,562	48
HSC - Childrens	130	41,169	87**
TOTAL		62,262	

* Grace hospital also admits adults to these beds and probably uses only 12 or 13 pediatric on a routine basis.

** Childrens Hospital will have 130 beds (new hospital) plus 10 psychiatric beds plus 6 ICU beds (total 146).

It was noted that Misercordia hospital had a length of stay of pediatric patients which was longer than at other hospitals. No reason for this anomaly could be found.

In order to provide an 80% occupancy rate the number of pediatric beds at the new Childrens Hospital (146) and St. Boniface Hospital (72) would accommodate 63,656 patient days. Population predictions for Manitoba to 1995 indicate a reduction in the number of children in the province by about 13,000 (age 0-14 years) (Appendix 3). These data support the concept of closing pediatric beds at the Misercordia and Grace hospitals.

Recommendation

THAT PEDIATRIC ADMISSIONS IN THE URBAN AREA BE LIMITED TO THE CHILDRENS AND ST. BONIFACE HOSPITALS.

Potential Benefits

1) Potential cost savings are possible provided either beds are closed or replaced by less labour intensive activities.
2) Average length of stay may be reduced.

Potential Difficulties

1) Current medical staff by-laws at St. Boniface hospital are restrictive. In order for medical practitioners to be able to admit to this hospital without interfering with other hospital privileges the pediatric facility will have to be designated as a special care facility and admission privileges liberalized.
2) Family practitioners may have difficulty in visiting pediatric facilities removed from their primary base of practice.
3) Current facilities and staff resources at St. Boniface hospital may have to be upgraded to accommodate an increase in the pediatric patient load.

Hypothesis 2: Hospital admissions of rural and urban children could be reduced by enhanced preventative health measures.

Data Base: Specific measures were not identified. The committee reviewed the report of the ad hoc Committee on National Health Strategies (Appendix 4). In Manitoba respiratory diseases account for the majority of admissions to hospital for children to age 12 years.

National health strategy identifies enhanced immunization programs as a potential beneficial preventative health measure. We did not identify data which indicated that lack of immunizations were responsible for increased admissions of children. Trauma, drowning, burns and poisonings were discussed as possible areas where prevention may have a cost impact.

Recommendations:

1) THAT PRIORITY BE GIVEN TO THE DEVELOPMENT AND EVALUATION OF INNOVATIVE PREVENTATIVE HEALTH PROGRAMS (E.G. UTILIZING TELEVISION) FOR HIGH MORTALITY AND MORBIDITY CONDITIONS WHICH ARE POTENTIALLY AMENABLE TO PREVENTION SUCH AS TRAUMA, DROWNINGS, BURNS AND POISONINGS.
2) FURTHER RESEARCH ON THE CAUSES AND PREVENTION OF RESPIRATORY DISEASE IN INFANTS AND CHILDREN IS NEEDED AND SHOULD BE FOSTERED BY THE PROVINCE OF MANITOBA.
3) THAT THE PUBLIC INCLUDING HEALTH PROFESSIONALS BE MADE MORE AWARE OF THE COSTS OF THE PRESENT HEALTH CARE SYSTEM BOTH ON AN INDIVIDUAL AND A GLOBAL BASIS AND AN ASSESSMENT OF THIS PROGRAMS EFFECT ON UTLIZATION OF THE SYSTEM BE MADE.

Hypothesis 3: Hospitalization of children could be reduced by an increased emphasis on ambulatory care.

Data Base: Discussion of this topic pointed out the following:

1) That hospital financing did not emphasize or create an incentive for ambulatory care as an alternative to in-patient care. For example, physiotherapy is readily available for inpatients but not outpatients.

2) That illness can be managed on an ambulatory basis and several programs have been shown to be cost effective (Appendix 5):

   (i) parenteral nutrition program
   (ii) day care surgery program at Childrens Hospital
   (iii) home I.V. program

Two models of budgeting were discussed:

   (1) Health Maintenance organizations
   (2) Ontario Programatic Budgeting which includes regional health councils

Recommendations:

1) THAT THE MHSC DEVELOP METHODS FOR FUNDING HOSPITALS THAT ENCOURAGE AMBULATORY CARE OF PATIENTS
2) THAT AMBULATORY CARE PROGRAMS BE FUNDED ON A PROGRAMMATIC BASIS RECOGNIZING THAT THEY EXTEND TO A WIDE AREA IN THE COMMUNITY AND CROSS JURISDICTIONAL LINES
3) THAT THERE BE AN ASSESSMENT AND ENHANCEMENT OF CURRENT AMBULATORY PROGRAMS AND DEVELOPMENT OF NEW AMBULATORY PROGRAMS IN AREAS OF DEMONSTRATED NEED WHICH WOULD PROVIDE AN ALTERNATIVE TO INPATIENT SERVICES. THIS MAY REQUIRE THE COORDINATED EFFORTS OF THE DEPARTMENT OF HEALTH (INCLUDING MHSC) AND OTHER PROVINCIAL DEPARTMENTS (E.G. EDUCATION). JOINT FUNDING MECHANISMS SHOULD BE CONSIDERED.

Hypothesis 4: More resources are needed for neonatal and pediatric intensive care; this would prevent long term morbidity of infants and children and would be cost saving. Part of these increased resources should include a total provincial transport system.

Data Base: Decreased mortality and morbidity statistics are readily available for neonatal intensive care. The committee ascertained that Dr. R. Livingstone's perinatal committee would address this portion of the hypothesis. Similar data for intensive care of children was not identified. It was noted that if a provincial transport system develops this will probably increase the need for high dependency beds. The committee discussed the number of pediatric ICU units required in the Province.

Recommendations:

1) THAT THERE BE ONLY ONE PEDIATRIC INTENSIVE CARE UNIT IN THE PROVINCE LOCATED AT THE CHILDRENS HOSPITAL
2) THAT A TOTAL PROVINCIAL TRANSPORT SYSTEM BE DEVELOPED FOR CRITICALLY ILL PATIENTS

Hypothesis 5: It would be cost effective to use other disciplines in the care of the patient for selected pediatric services rather than use a physician.

Data Base: A number of studies were cited which supported this hypothesis (Appendix 6).

Recommendations:

1) A NEONATAL NURSE CLINICIAN PROGRAM IS URGENTLY NEEDED AND SHOULD BE IMPLEMENTED AS SOON AS POSSIBLE
2) MHSC AND THE DEPARTMENT OF EDUCATION ASSESS THE NEED AND COST EFFECTIVENESS OF OTHER SELECTED NURSE PRACTITIONER PROGRAMS

Hypothesis 6: Inadequate rehabilitation services are increasing costs in the long term.

Data Base: There is an urgent need for resources for both acute and chronic pediatric rehabilitation services such as physiotherapy, occupational therapy and speech therapy. Patients are now having to be admitted to hospital in order to receive adequate physiotherapy since cutbacks in staffing have required a concentration of effort on in-patients. The Rehabilitation Centre for Children was considered to be limited in its programs and utilization of services are ineffective because of its location (Appendix 7).

Recommendations:

1) THE FINANCING OF REHABILITATION PROGRAMS FOR CHILDREN BE REVIEWED AND THAT ADEQUATE RESOURCES BE APPROPRIATED.
2) A COMPREHENSIVE PROVINCIAL PEDIATRIC REHABILITATION PROGRAM SHOULD BE DEVELOPED. THIS PROGRAM SHOULD BE BASED AT THE HEALTH SCIENCES CENTRE SITE IN CONJUNCTION WITH THE CHILDRENS HOSPITAL AND THE REHABILITATION CENTRE FOR ADULTS AND SHOULD PROVIDE A CONSULTATION/EDUCATION SERVICE FOR THE PROVINCE. THE REHABILITATION CENTRE FOR CHILDREN SHOULD BE CLOSED.

Hypothesis 7: Regional services based on provincial programs should be expanded and may reduce morbidity and mortality with a reduction in health care costs.

Data Base: Genetic Counselling services were used as a model and there are data which support this hypothesis (Appendix 8). A development of family centered reproductive programs is another program which may support this hypothesis. In extrapolating from the principles of genetic counselling services, provincial programs should be considered when the following conditions are met:

a) there is multi health professional involvement in the management of complex pediatric problems (e.g. arthritis, oncology, cystic fibrosis and other chronic respiratory diseases).

b) the conditions are sufficiently infrequent that expertise in a given region would be limited.

The development and coordination of these programs should be in conjunction with the expertise available.

Recommendation:

THAT FURTHER ASSESSMENT OF THE NEED FOR PROVINCIAL PROGRAMS WHICH PROVIDE A REGIONAL SERVICE BE UNDERTAKEN IN CONJUNCTION WITH THE APPROPRIATE EXPERTS IN THE PROFESSIONAL DISCIPLINES.

Final Observation:

The committee did not enter into extensive discussions regarding admissions of pediatric patients to rural hospitals (Appendix 10). It was noted that occupancy rates varied from 18 to 78%.

Recommendation:

THAT FURTHER STUDY OF RURAL PEDIATRIC BEDS SHOULD BE MADE.

APPENDICES - Available upon request

Appendix I

Tables: M.H.S.C. Pediatric Cases by Classification and Age Group for the years 1979/80 to 1983/84.

Appendix II

Table: Statistics Canada Population Projection by Age for Manitoba, 1984 and 1995.

Appendix III

Report of the Ad Hoc Committee on National Health Strategies

Appendix IV

1. Statistical report on Home Parenteral Nutrition at Health Sciences Centre, Children's Hospital for the time period of April, 1979 to September, 1984.
2. Publication - Estimating the Effect of Hospital Closure on Areawide In-patient Hospital Costs: A Preliminary Model and Application.
3. Publication - Community Correlates of Hospital Use.

Appendix V

1. Publication - Potential Savings from the Adoption of Nurse Practitioner Technology in the Canadian Health Care System.
2. Publication - Quality of Patient Care by Nurse Practitioners and Physician's Assistants: A Ten-Year Perspective.
3. Publication - Effect of Clinical Settings on the Utilization of Nurse Practitioners.
4. Publication - Assessment of the Role of the Family Practice Nurse in Urban Medical Practices.
5. Publication - An Evaluation of Efforts to Educate Mothers about Child Development in Pediatric Office Practices.
6. Publication - The St. John's Randomized Trial of the Family Practice Nurse: Health Outcomes of Patients.

Appendix VI

Statistical Report of the Rehabilitation Centre for Children 1981/82 - 1984/85.

Appendix VII

1. Publication - Genetic Counselling

2. Publication - Maternal Serum Alpha - Feto protein

   Screening - A Cost-Benefit Analysis

3. Publication - A Cost-Benefit Analysis of a Population Screening Programme for Neural Tube Defects

Appendix VIII

M.H.S.C. Report on Hospital Utilization of Manitoba Residents with Diabetes Mellitus 1979/80 - 1983/84.

Appendix IX

M.H.S.C. Report on Rural Pediatric Information

Appendix X

Minutes of Meeting

Appendix XI

Correspondence

RESPIRATORY SUB-COMMITTEE

INTRODUCTION

The following represents the response of a committee charged by the MHSC with examining current trends and future projections of respiratory disease in Manitoba. The Committee was composed of

Dr. N.R. Anthonisen, physician, Winnipeg, (Chair)
Dr. J. Manfreda, epidemiologist, Winnipeg
Ms. L. Fredette-Feaks, social worker, Winnipeg
Ms. J. Porth, home care nurse, Winnipeg
Dr. D.C. Johnson, physician, Pinawa, Manitoba
Mr. S. Drain, MHSC

The Committee reviewed the current status of respiratory diseases and their care in Manitoba, confining its scope to adult patients, that is those of 15 years of age or more. The review was carried out in the context of an effort to contain costs. That is, the various portions of the health care system were examined in an effort to determine how to decrease the number of dollars expended on them. The Committee further confined its consideration to the next 5-10 years, believing that predictions over a longer term would be very unreliable, though the Committee believes that its recommendations will probably apply to the more distant future.

The report will consider the prevention of respiratory disease, medical services and hospitalization for respiratory disease, the long term care of patients with respiratory disease, and possible medical advances in respiratory disease. Finally, the Committee made a series of recommendations that it believes would help control costs without compromising the quality of care.

PREVENTION

By far the most important known avoidable cause of respiratory disease is smoking, the direct cause of at least 90% of lung cancer and chronic obstructive pulmonary disease, and an important contributor to more minor illnesses. Smoking is currently declining, and it is perhaps reasonable to hope that in 20 years the habit will be confined to a distinct minority of the population. It should be noted that the decrease in smoking is uneven, being much more prominent in males than females and more striking in upper socio-economic classes, which tend to have less chronic respiratory disease. Further, the damage done by smoking is cumulative and long term, so the effects of present-day changes in smoking habits will probably not be observed for at least 10 years, that is, actual declines in the incidence of diseases caused by smoking are unlikely to occur sooner. On the other hand, previous changes in smoking habits may decrease the increases in the incidence of these diseases that would otherwise be expected on the basis of population aging.

The precise cause of the decrease in smoking prevalence in unclear, but it has been coincident with widespread publicity emphasizing the harmfulness of the habit. This publicity has taken many forms and has originated in both the public and private sectors. Its continuation should be encouraged. However, because anti-smoking information has been so varied and pervasive, the effects of single campaigns are unknown and probably unknowable, except for a few specifically targetted and very expensive efforts. Therefore while anti-smoking efforts which contribute to the general anti-smoking atmosphere should be encouraged, very expensive, specific efforts should be examined in terms of cost effectiveness against a background of declining prevalence of smoking. No specific aproach has been shown to "cure" smoking.

One other respiratory disease, tuberculosis, is preventable and theoretically eradicable. The approach to tuberculosis control presently practiced in Manitoba is a model one in terms of organization and effectiveness. In spite of this, tuberculosis incidence is declining very slightly if at all. The failure of current efforts to eliminate this disease as a health problem reflects social as opposed to medical issues, the most important being immigration from the third world where the disease is poorly controlled, and the socio-economic status of native people which is in many ways similar to that of third world citizens.

MEDICAL SERVICES

Medical services for respiratory diseases in people over 14 years of age are shown in Table 1, for the years 1979 and 1983 with the dollars spent in each diagnostic category and an inflation adjustment for the latter year, ($0.60 in 1979 = $1.00 in 1983). Several overall trends are clear. The number of physicians' services per patient tended to increase. In spite of this, the amount spent in constant (1979) dollars decreased by nearly $500,000, reflecting the fact that the price per service lagged far behind the overall inflation rate. The number of patients in some diagnostic categories - asthma, allergic rhinitis - underwent major increases, but these were few. The large decrease in the prevalence of TB can be ascribed to shorter courses of therapy and the large number of recent immigrants from Southeast Asia in the province in 1979. Most important, total dollars spent on respiratory diseases was not large - when compared to hospitalization costs - and nearly 40% of this was spent in connection with upper respiratory infections.

Cost control of medical services in respiratory disease will have little impact on total health spending in this category and cost control of medical services will be ineffective unless applied to upper respiratory infections, which are very common, usually of little long term health significance, and unlikely to increase or decrease in the near future. Probably the only effective cost control measure that can be applied to medical services would be some sort of deterrant fee, which would have the undesirable potential of creating a two track medical system.

HOSPITALIZATION

Table 2A contains a sampling of daily rates from representative acute care hospitals in Manitoba. These figures are derived by dividing hospital global budget by total patient days, and it is impossible to separate respiratory patients from others. Further, though the institutions listed are nominally acute care institutions, it is almost certain that included in the "patient days" used in the rate calculation for each hospital are patient days of long stay, non-acute patients. Though such patients need a lower level of service than others in acute hospitals it is most unlikely that the actual cost for such patients is as low, at least in Winnipeg, as in institutions specializing in chronic care, shown in Table 2B.

Per diem costs vary widely. Unique services contribute to the very high cost of the Winnipeg teaching hospitals, and remoteness to the relatively high cost of Thompson General Hospital. It is probable that the very low cost of some rural hositals is in large part due to a large fraction of long-stay patients. It is clear that some of these hospitals are financially competitive with Winnipeg long stay institutions and can therefore function as long stay institutions with relatively little financial penalty to the Province.

Hospitalization data for respiratory diseases in adults for 1983-84 are shown in Table 3, which uses the same diagnostic criteria as Table 1. Shown are cases hospitalized, patient days, and average stay. In addition the percent of hospitalized patients that live in Winnipeg are compared to the percent of total patients hospitalized in Winnipeg hospitals. Overall, approximately 128,000 patient days were attributable to respiratory disease. If the average per diem rate was $250-$300, the total cost was $32,000,000-$38,000,000, a figure which dwarfs other provincial spending in this category. Further, 76% of the total patient days were accounted for by pneumonia, COPD and lung cancer, diseases of old people which may well increase in incidence as the Province's population ages.

Several interesting trends emerge from Table 3. Lung cancer, a disease for which virtually all patients are hospitalized, is distributed roughly according to population - 55% of the patients are from Winnipeg. However, 73% of the patients hospitalized with lung cancer are hospitalized in Winnipeg and nearly 80% of the patient days are spent in Winnipeg hospitals. Patients from outside Winnipeg with lung cancer are sent to Winnipeg for hospitalization, which is appropriate. The same trend, which is also appropriate, is seen in the case of tuberculosis, and in other non-infectious lung disease which include severe lung fibrosis. Diseases such as URI and bronchitis, which are largely self-limited and involve relatively short hospital stays, result in many fewer hospitalizations of Winnipeg than rural patients. Relatively few of the patients with these diseases are hospitalized in Winnipeg and they account for only a small fraction of the total patient days attributed to these diagnoses. People from Winnipeg were hospitalized less often for pneumonia and chronic obstructive pulmonary disease (COPD) than patients from rural areas - 34% and 42% respectively of hospitalized patients were from Winnipeg, and these diseases are as common in

Winnipeg as elsewhere. Some rural patients are sent to Winnipeg for hospitalization with these diagnoses, and patients in Winnipeg hospitals have appreciably longer stays, accounting for a disproportionate share of patient days. Presumably, these patients were sicker.

Some of these data might suggest that by Winnipeg standards, in rural areas there are unnecessary hospital admissions, and that these areas are overbedded, assuming that the diseases involved have roughly equal incidence inside and outside Winnipeg and that diagnostic standards are not systematically different. However, it must be recalled that out-patient access may be more limited and difficult in rural Manitoba than in Winnipeg, and if such were the case it would be reasonable to expect higher hospitalization rates of doubtful cases in rural areas. We cannot assess the importance of this factor accurately.

LONG TERM CARE FACILITIES

Elderly patients with chronic disease make up a substantial share of those with respiratory illness, and demand a disproportionate share of community health resources. As the average age of the population increases, this demand will increase. At present such patients occupy a meaningful fraction of acute hospital beds: 10-20% of the beds in the Respiratory Centre of the Health Sciences Centre for example. This is totally inappropriate, at least in Winnipeg, where acute care beds are very expensive. Alternative long term care facilities therefore should be an important part of a overall plan for the management of respiratory disease.

Before considering facilities, the specifics of patients with chronic disabling respiratory disease should be considered. In general, there are three kinds of patient in this category. First, there are a substantial number of patients disabled by inoperable lung cancer, who need palliative care, and who live only a short time. Second, there is a small group of patients who are dependent on artificial ventilation. Most of these are holdovers from previous polio epidemics, and because of this these patients will decrease in number. Third, there is a substantial number of patients with chronic non-malignant lung disease who are disabled by severe shortness of breath. The severity of this symptom is such that the patient is unable to cope with many routine activities of daily living. Most of these patients are on continuous oxygen therapy. We will consider how currently available long term care arrangements meet the demands of these patients, assuming that their respiratory illness is the chief determinant of their disability. We shall not, for example, consider the case of the individual in whom lung disease and senile dementia coexist, since the latter condition is far more likely to be the chief cause of inability to return home.

Institutions for long term care consist of four kinds of facility: residential care, elderly persons housing (EPH), personal care homes (nursing homes), and extended care hospitals. Currently, patients on ventilators are managed only in the last of these. At the present time, it is very difficult to obtain beds in extended care hospitals for such patients, but because they are very uncommon, this is not a major problem. Patients with inoperable lung cancer are best managed in palliative care units and since waiting periods for such beds are presently short, it appears that these facilities are adequate and at least insofar as lung cancer is concerned, are likely to remain so. Thus the full range of chronic care facilities need be considered only in relation to patients disabled by shortness of breath, who at present constitute by far the largest problem of occupancy of acute care beds.

Residential care homes are relatively cheap accommodations, but are not designed to deal with patients disabled by disease, and so are of no relevance to patients with severe shortness of breath. E.P.H. supply living space for elderly people. They also are not geared for dealing with the chronically ill; in only a few can meals be obtained that are not prepared by the occupant. On the other hand, the Provincial Home Care Program can provide services to the occupants of E.P.H. These facilities should be regarded as a low-maintainance alternative to the home and are useful to the chronically short of breath only insofar as they can be managed by Home Care. There is at present a 6 month waiting period for E.P.H. which may be appropriate, since the decision to move to one is essentially to change living quarters, and should seldom be necessitated by respiratory disease.

Facilities designed to manage the chronically ill include personal care homes (P.C.H.) and extended care hospitals (E.C.H.). The former cost $62.75/day for the sickest patients, the latter cost $150/day. Access to both is severely limited in Winnipeg, with waiting periods of 3-8 months indicating a major shortage of beds. In the case of patients disabled by shortness of breath substantial fractions of this waiting time are spent in acute care beds. At present, many patients disabled by shortness of breath demand no more care (3.5 hours/day) than that available in P.C.H. However, very few enter these facilities because they - the P.C.H. - will not accept patients on long term oxygen therapy. There is no rational reason for this prohibition, and it should not be accepted. Patients on long term oxygen therapy presently have access only to extended care hospitals for chronic care. At present, these institutions are not ideal for patients with respiratory disease, since they are mixed with patients with senile dementia. Some sort of segregation of respiratory patients would be more humane than the current arrangements.

Negotiations are under way for segregated respiratory beds at the Municipal Hospitals. It is likely that 25 such beds will be available this year and plans are being made for another 25. This may relieve a great deal of pressure on acute care beds and with a more enlightened P.C.H. policy and increased P.C.H. beds, solve the problem of chronically ill patients who cannot be managed at home, and provide for respite care for patients who are managed at home with difficulty.

HOME CARE

Manitoba's home care program is designed to meet the functional needs of persons with chronic disease and to manage their illnesses in the home as opposed to hospitals or long stay institutions. The program, particularly as it relates to respiratory patients, is an internationally recognized model of excellence. Manitoba chest physicians are regularly asked to write or lecture about home care for non-Canadian audiences. In total the home care program manages approximately 20,000 patients a year, admitting about 9,500, and discharging a slightly smaller number, so that at any single time the caseload averages some 11,000 patients. The case load has been increasing at approximately 5% per year. In recent years the number of services, especially those involving nursing and home making have increased more rapidly, indicating an increased demand and perhaps increased disability on the part of the individual patient. Over the last year or so, the number of services per patient has shown signs of levelling off. To some degree, the home care caseload and service requirement reflect the availability of personal care home beds; when such beds are in short supply, as is the case in Winnipeg, the patients on the waiting list are most likely on home care, and need a high level of service.

Though home care caseloads and service loads have grown consistently since the program began, its budget, particularly for case workers or field staff, has not kept pace, and at present caseloads of individual workers are too large to permit continuous program assessment. The result is that patient home care plans tend to be reviewed only in moments of crisis. This may be expensive in the long run, since failure of prospective periodic review probably results in overutilization of services as opposed to the reverse, and funding has been easier to obtain for specific services than for administration. In spite of budgetary problems, there is no apparent waiting list for the home care program: patients referred to the program are promptly assessed and when appropriate promptly enrolled. This is the only Manitoba program for the chronically ill, except for palliative care, that can make the above statement.

The average cost of the total home care program is approximately $1,200 per patient served per year, a very small fraction of the institutional alternatives.

In Winnipeg, some 5-6% of home care patients have a primary diagnosis of respiratory disease; this is an approximation based on a recent survey, a more accurate figure being very difficult to obtain. Most of these patients are disabled by chronic breathlessness. Approximately a third demand a high level of service, most receiving continuous home oxygen therapy supplied by a machine purchased and maintained by home care. It is difficult to ascertain the costs of home care for respiratory patients, but for those on 0_2 it has been estimated at $5,200 per patient per year. It is important to recognize that this price includes the "capital" cost of the oxygenator, which is about $3,000; these machines can almost certainly be used for more than one patient. That is, after a patient is discharged from the program the machine assigned to him or her can be reassigned to another patient. Thus the figure of $5,200 per patient/year will decline in the future. Whether the cost declines or not, it is still a small fraction of the $22,000 per patient year or the $54,000 per patient year necessary to maintain patients in personal care homes or extended care hospitals, respectively. Home care is heavily utilized in the management of patients with severe breathlessness. About 500 currently receive home care, most because of chronic obstructive pulmonary disease (COPD). In the Province 1,800 of these patients were hospitalized in the past year, so a very substantial fraction of Manitobans with severe COPD are on home care.

FUTURE PERSPECTIVES

It is difficult to predict with accuracy future trends in respiratory disease. It is not clear how much the burden of respiratory disease will increase over the next 5-10 years. On the one hand, chronic respiratory disease will increase as the population ages. On the other, cigarette smoking, by far the most important cause of chronic respiratory disease is declining and this decline is beginning to be reflected in the prevalence of some diseases. For example, the lung cancer rate in men shows signs of levelling off after decades of steady increase. It is probable that the incidence of respiratory disease will increase in the next 5 years at the same modest rate - 10-15% - that it has in the past 5 years, and there are no good data to suggest that there will be major changes in the next 10 years.

It is highly unlikely that there will be major advances in the treatment of respiratory disease in the next 5 years and somewhat unlikely that these will occur 5-10 years from the present. Minor advances may occur in the treatment of lung cancer; these will be expensive. The acquisition of good facilities for computerized tomography will simplify and make cheaper the diagnostic workup these patients undergo. It is unlikely that other high tech developments will have major impact in respiratory disease: artificial lungs, and lung transplants are still totally experimental, and new imaging techniques, such as nuclear magnetic resonance and positron scanning do not yet show clear evidence of clinical utility.

Thus for the near term, we believe planning should be based on the assumption that the incidence of respiratory disease will increase gradually and the treatment will undergo little change.

CONCLUSIONS AND RECOMMENDATIONS

By far the largest expenditure for respiratory disease involves' hospitalizations in acute care institutions. Though hospital per diem rates are very high, it is likely that they underestimate the real costs accrued by patients acutely ill with respiratory disease, since per diem costs are the average cost of these acutely ill patients and other long stay patients. Therefore, if important sparing of health care dollars is to be achieved, it must be by decreasing hospital costs, and this can only be done by closing hospital beds. The following suggestions are aimed at this goal.

Due to global budgeting it is impossible to acquire other than global estimates of bed utilization. It is very likely that all Provincial acute care hospitals have a population of long stay patients who are in hospital because alternate facilities are not available. Outside of Winnipeg, this may not be a source of great concern, since the per diem charge of some rural hospitals is similar to that of extended care institutions. In Winnipeg, this is almost certainly wasteful, since it is unlikely that per diem costs in very expensive institutions like the Health Sciences Centre and St. Boniface Hospital are as low as $150/day even for long stay patients. Long stay patients should not be in these hospitals unless they are in clearly designated units for clearly understood reasons and efforts made to assess the real cost of these units. Similar evaluations of the number, level of illness and cost of long stay patients should probably be attempted at all Manitoba hospitals. It is very likly that substantial numbers of patients suitable for personal care homes and extended care facilities are occupying "acute" beds at excessive expense.

In the U.S.A., massive efforts at hospital cost control are underway, centering around funding according to diagnostic related groups (DRG). They will undoubtedly succeed to some extent, though it is not certain that they will not have a negative effect on patient care. They do have the effect of putting both professional and administrative staff under pressure to perform efficiently. At present, with global budgeting there is little pressure of this kind in Manitoba. Average patient stays in Manitoa hositals are substantially longer than in analogous hositals in the U.S.A. Part of the discrepency is due to the more humane government supported health care system in Manitoba - Manitobans are undoubtedly less sick at discharge than are North Dakotans - but part of the discrepency is probably due to the fact that because Manitoba hospitals are under relatively little pressure to operate efficiently, they operate inefficiently. For example, at the H.S.C., it is not uncommon to wait 24-48 hours ($455-$910) for a laboratory report. Some variation of prospective, case by case hospital funding analogous to DRG's should perhaps be considered in Manitoba. The U.S. experiment should be followed with interest.

Hospitalization data can be interpreted as suggesting that at least for respiratory diseases, hospitals outside Winnipeg are overbedded for acute care in comparison to Winnipeg. This possibility needs to be investigated, and if a pattern of hospitalization for minor illness is consistent and not explicable in terms of out-patient accessibility, other uses of these beds should be considered. They could be converted to long stay beds and it is possible that such beds could be used by selected patients from Winnipeg.

A major problem with the Manitoba health care system is that development of out-patient facilities has seriously lagged that of in-patient ones. One result is that patients are usually admitted to hospital for diagnostic studies, the only justifications for this being convenience and access to hosital based facilities. For example, virtually all patients with lung cancer are admitted for work-up while this is a medical necessity in only a minority. In this specific instance out-patient work-up would be feasible if hostel facilities were subsidized, if hospital diagnostic facilities were readily accessible, and if laboratory reporting were prompt. Some 8-10 beds (20-25% of the total) at the Respiratory Centre of the H.S.C. are taken up by patients undergoing diagnostic work-up for lung cancer, which currently takes 8-14 days ($3,500-$6,500). This alternative to hositalization should be vigorously investigated, at least at St. Boniface General Hospital and H.S.C. Upgrading diagnostic facilities and communication would be expensive, but this would be made up by the difference between hospital and hostel per diems, and increased efficiency of hosital diagnostic facilities would tend to shorten hospital stays in acutely ill patients.

There is a shortage of personal care homes in Manitoba, evidenced by the current long waiting lists for beds at these institutions. At present this arm of the health care system is underutilized by patients with respiratory disease because these institutions will not accept patients on continuous oxygen therapy. There is no rational reason for this and it should not be permitted to continue. The result of this personal care home policy is that patients on oxygen therapy who need long term institutional care receive this care in extended care hospitals, though their nursing needs may not exceed the 3.5 hours a day upper limit for personal care homes. More beds and a change of oxygen policy are both needed, at least in Winnipeg.

There are also not enough extended care hospital beds in Winnipeg, again evidenced by waiting lists, and it should be noted that respiratory patients often "wait" for these beds on the wards of acute care hospitals. Major beneficial changes for respiratory patients are currently being negotiated between the Municipal Hositals and the Respiratory Cetre. These should be facilitated and encouraged. Given these potential changes and increased access to personal care homes,it is not clear that a further increase in respiratory beds at extended care hospitals is necessary, but the waiting list for other diagnostic categories clearly indicates a need for increased beds of this nature for Winnipeggers.

The Provincial Home Care Program is by far the most cost effective mechanism for the management of chronic disease in Manitoba. At present it functions very well: the care is good and services are provided promptly. Cost saving in terms of underfundng its administration may be introducing inefficiencies in the system, however. Maintainance of this program and the morale of those who work in it should be high priority for those concerned with provincial health care.

TABLE I Medical Services

	Patients	Services	Service/ Patient	Expenditures	1983 Expenditures in 1979 Dollars
URI (460-465,487)					
1979	137,468	232,979	1.69	2,057,955	-
1983	150,202	297,253	1.98	3,039,933	1,985,960
Allergic Rhinitis (477)					
1979	10,191	48,229	4.73	399,438	-
1983	12,285	62,575	5.09	794,469	476,861
Bronchiolitis, Bronchitis (466)					
1979	10,734	23,030	2.15	190,748	-
1983	10,987	23,423	2.13	273,664	164,198
Bronchitis (490)					
1979	35,620	79,599	2.23	621,340	-
1983	37,083	85,739	2.31	935,645	572,187
Pneumonia (480-486)					
1979	10,968	50,891	4.64	386,747	-
1983	12,447	60,267	4.83	659,599	395,759
COPD (491,492,494,496)					
1979	13,565	68,247	5.03	512,149	-
1983	14,735	92,983	6.31	983,905	590,343
Asthma (493)					
1979	9,831	52,683	5.36	453,724	-
1983	12,190	67,064	5.50	810,611	486,367
Other - Non-Infectious (495,501,502,506,507,516)					
1979	358	1,670	4.66	13,610	-
1983	306	1,761	5.75	25,262	15,157
Pleural (510-513)					
1979	2,443	9,519	3.90	100,544	-
1983	1,885	7,868	4.17	135,524	81,314
Pulmonary TB (011)					
1979	1,839	10,085	5.48	73,885	-
1983	931	5,707	6.13	65,776	39,460
CA Lung (162)					
1979	1,408	21,736	15.44	260,226	-
1983	1,438	26,692	18.56	435,678	261,407

TABLE 2 - Per Diem Hospital Costs

A. Acute Care Hospitals	
Urban	
Health Sciences Centre	455.10
St. Boniface Hospital	410.50
Grace General Hospital	249.30
Brandon General Hospital	254.80
Rural	
Thompson General Hospital	294.95
Steinbach General Hospital	162.30
Selkirk General Hospital	218.95
Flin Flon General Hospital	224.50
Beausejour General Hospital	131.50
Pinawa General Hospital	277.40
Russell General Hospital	137.55
B. Chronic Care Institutions	
The Municipal Hospital	157.90
Deer Lodge Centre	150.00
Beacon Hill Lodge	62.75
East-Gate Lodge, Beausejour	67.30
Villa-Youville, St. Anne	60.35

TABLE 3 - Hospitalization Data

ease	Cases	Pt. Days	Av. Stay (days/case)	% P-D* in Wpg.	% Pts.+ in Wpg.	% Pts.o from Wpg.	Days/1000 Population
(460-465)	714	3,445	4.8	15	14	17	4.1
nchiolitis- onchitis (466)	457	3,084	6.7	17	14	17	3.7
nchitis (490)	265	1,772	6.7	13	7	11	2.1
umonia (480-486)	2,394	46,549	19.4	49	35	34	55.2
D (491,492,494, 6)	1,844	29,293	15.9	60	46	42	34.7
hma(493)	1,392	9,668	6.9	50	43	43	11.5
er Non-infect 95,501,507,516)	112	6,131	54.7	83	68	50	7.3
ural (510-513)	254	2,893	11.4	68	55	46	3.4
monary TB (011)	125	3,314	26.5	92	84	50	3.9
Lung (162)	1,072	22,251	20.8	78	73	55	26.4

ercent total patient days spent in Winnipeg Hospitals

ercent of patients hospitalized in Winnipeg

ercent of hospitalized patients who are from Winnipeg

REPORT

SUB-COMMITTEE ON THE TERMINALLY ILL

INTRODUCTION

Although "terminally ill" in every day speech is equivalent to dying from malignant disease, the equivalence is only symbolic. Other categories of disease terminate in death. The hospice or palliative care movement (see Appendix I), rising from a sense of indignation at current practices in caring for the dying, has concentrated on cancer deaths. Despite the tendency to identify care of the terminally ill with cancer patients, our recommendations to the Health Services Review Committee have a broader scope.

There has been a recent article bearing on this area from a social policy perspective, (see Appendix II). The Abstract of the article merits quotation in full:

> "Are current expenditures on dying patients disproportionate, unreasonable or unjust? Although a review of empirical data reveals that care for the terminally ill is very costly, it is not appropriate to conclude that such expenditures represent morally troubling misallocation of societal resources. Moreover, though efforts to reduce the costs of caring for the dying are not unreasonable, they must be undertaken with great caution. At present, such efforts should concentrate on three basic goals: development of better criteria for admission to intensive- and critical-care units; promotion of patient and family autonomy with regard to the decisions to stop or refuse certain kinds of treatment; and promotion of alternative forms of institutional care, such as hospice care.
>
> The most difficult moral problems will arise when patients and their physicians seek access to therapies judged only marginally useful. There may be conflict between administrators with broad institutional responsibilities and clinicians committed to particular patients. (New England Journal of Medicine, 1983; 309:1490-4.)"

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1. RECOGNITION OF THE TERMINALLY ILL

Before the terminally ill can be cared for they must be identified, an action which is not as easy as identification in retrospect. However, retrospective identification has made one aspect of the care of the terminally ill very prominent: approximately one fifth of health care expenditures in the United States are taken up by "the costs of caring for patients who are terminally ill with cancer and for those who do not survive after treatment in critical- or intensive-care units." (See Appendix II - Page 1491). But, for the individual patient and for the health professional, in a society characterized as "death denying", the identification of terminal illness is uncertain, stressful, discouraging, demoralizing, alienating ---- and evadable. The first requirement of a policy for care of the terminally ill must be to facilitate recognition of "an illness in which, on the basis of the best available diagnostic criteria and in the light of available therapies, a reasonable estimation can be made prospectively and with a high probability that a person will die within a relatively short time." Criteria development has been started: References 8 and 9 in Appendix II.

Recommendation:

Because determination of terminal illness is a judgment based on considerations of diagnosis, prognosis and treatment, the College of Physicians of Manitoba should be encouraged to develop and review this aspect of standards of medical care.

Comment:

This recommendation has implications beyond the care of patients terminally ill with cancer since it applies potentially for intensive care units as well. It seems possible that inappropriate and costly intervention might be reduced through improved determination of terminal illness.

2. PROMOTION OF AUTONOMY

Whatever precision medicine may achieve in determining diagnosis, prognosis and available therapies, the patient is autonomous under law, with regard to medical intervention. Some patients accept therapy, some are biased to minimal intervention and some would prefer to "gamble" with experimental therapy (experimental therapy being contrasted with standard or established therapy). The individual physician, when recommending therapy, is naturally biased by his or her particular professional experience and skill as well as by values and anxieties that are personal rather than professional. The "promotion of patient and family autonomy with regard to decisions to stop or refuse certain kinds of treatment" cannot be left to the physician, even though the profession, under law, must recognize that autonomy. How then: "promote autonomy?"

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It is apparent that diagnostic and therapeutic activity for serious illness, including terminal illness, occurs mainly in relation to hospitals. In that setting the board carries overall responsibility for the well being of the patient. The board appears to us an appropriate institution in our society to promote autonomy. But how? Recently suggestions have been made to incorporate an expression of the patient's wishes in the hospital admitting process. (New England Journal of Medicine, 1984, April, Angell, M.).

"Do you wish to be fully informed of medical findings and consulted on all important decisions during your hospitalization?

YES ________ NO________

If so, do you have any objections to having your family informed as well as yourself?

YES________ NO________

If you do not wish to be fully informed, would you like to designate a family member or someone else to be kept informed in your stead?

NAME________________________ NO________"

It might be appropriate to have information and staff, readily available, specifically for these civil rights matters. The most prominent rights are:

1. information, including diagnosis, treatment alternatives and second opinion and

2. acceptance or refusal of procedures, both diagnostic and therapeutic.

The Human Rights Commission and/or the Manitoba Association of Rights and Liberties might be helpful sources for the formulation of hospital procedures.

Recommendation:

Because the promotion of patient autonomy is appropriate to hospitals boards, the Manitoba Health Organizations should be encouraged to help boards develop and implement procedures to promote autonomy.

Comment:

The wish for information was foremost of the wishes listed in the report "Health - A Need for Redirection" (Task Force on the Allocation of Health Care Resources, 1984 Appendix III). It appears that physicians tend to promote aggressive intervention under the influence of ambiguous Canadian law regarding negligence (see Appendix IV - Law Reform Commission Report, Page 23). It seems likely that this recommendation would lead to some lessening of intensive care for the terminally ill, whether from cancer or other illnesses.

3. PROMOTION OF HOSPICE CARE

The hospice movement has developed in response to a perception that care of the terminally ill is often inappropriate. This has lead to a variety of programs, largely for cancer patients, which concentrates on comfort-care and sustaining the dignity of the individual patient and family in the face of inevitable death. There has been sufficient experience in Canada and elsewhere to anticipate the impact of "promotion of alternative forms of institutional care, such as hospice care."

Hospice or palliative care has been extremely well received by patients and families. Only crude cost studies are available. The Royal Victoria Hospital Palliative Care Unit has estimated that cost per patient day in the unit is approximately the same as in an acute ward. The costs are distributed differently: the palliative care unit costs are more for personnel and less for investigation and treatments. A British Columbia government study of Hospice Victoria concluded that total cost incurred during the terminal days of illness, combining in-patient and home care costs, was at least 10% less in the hospice program. (See Appendix V). Preliminary data from the palliative care unit of St. Boniface Hospital suggests a significant preventive saving for family of the dying patient: less deaths and hospital use by the widowed spouse during the first year of bereavement when the patient died in palliative care than in other hospital settings. (See Appendix VI).

How can palliative care be organized to be both appropriate and economical? The Canadian and international experience is structured on two links: patient-family and home-hospital. Palliative care always tries to include the family in arranging care: shared information and shared responsibility. Close relatives typically are expected to take on increasing responsibility with regard to decisions as the patient's capacity may decline with illness. This shift of responsibility must be geared to the patient's real failing in order to protect the patient from overzealous family; the professional role is to help estimate declining capacity and counsel the family's care-giving activity.

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The link between home and hospital must also be strengthened. It is widely held that being at home is better, as well as cheaper, if the hospital is unable to offer cure or improvement. This view presumes the family's readiness to take on care for a patient so sick that death is inevitable, usually without previous experience of death, without "medical skills" to help ease the dying patient during the hours of dying. To achieve dying at home the family must be sure of help at home or expeditious admission to hospital in the event of critical change in the patient or of their own exhaustion. These are the organizational assumptions of palliative/hospice services.

What resources are needed? How is staff to be prepared? These questions must be dealt with separately.

3a. Resources

The good news is twofold: Manitoba has a universal home care program available equitably to the terminally ill and hospitals are already looking after the terminally ill under universal prepaid hospitalization. There is no need for additional facilities. If the suggestive experience referred to can be generalized, there should be a saving of hospital use and costs. Our recommendations are for redesignation of hospital beds for palliative care units based on 1) Canadian Standards, National Health and Welfare, for unit size and 2) estimates of beds per hospital for population served according to British standards. Application of the hospital-home care model should be individual for each institution. Institutions can find consultation resources in the Manitoba Health Services Commission,

the Canadian Palliative Care Foundation in Toronto and pre-existing programs in Manitoba: the St. Boniface General Hospital, the Municipal Hospital and the Assiniboine Hospital Palliative Care Units.

In Britain the highest hospice bed ratio is 50 beds per million population (Reference: The British Medical Association Journal, Volume 283, 1981, August 29, Pages 595 - 598, Table II). A ratio of 100 beds per million is suggested for Manitoba because the British ratio is not able to meet the real need at the present time and because the British population is much more concentrated and more easily reached with home care services. There were 1800 cancer deaths in Manitoba last year, which would make an average of 18 deaths per hospice bed per year (Appendix VII).

Two principles were considered to guide proposals for Manitoba:

1. No unit should be smaller than 12 beds, according to federal guidelines.
2. To the extent possible, there should be continuity of care: patients should be able to be cared for until death in the facility of their choice, usually where they have been cared for earlier.

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3a.(1) Rural

No area outside Winnipeg and Westman needs the number of beds to justify a specialized palliative care unit. The rural areas could use an existing unit, usually a general medical ward, where it would be preferred to place terminally ill patients. These units could undertake to assure availability of beds as needed for admission, just as the formal palliative care units would. In rural areas the development emphasis would be on preparing staff to look after terminally ill patients on the same ward as other medical patients.

3a.(2) Urban Areas

The principles quoted above would exclude smaller urban facilities from having a palliative care unit. They might consider providing a service similar to rural hospitals as described above. The recommended complement of beds could be divided among facilities sufficiently large to have an efficient sized unit. This would obviously include Brandon, where a facility exists at the Assiniboine Centre. It would certainly include St. Boniface Hospital and Health Sciences Centre. St. Boniface has a unit at the present time. A third unit could be located to serve the areas related to Grace and Misericordia Hospitals or continue to be located at the Municipal.

The principle of continuity of care would suggest closing the present unit at Municipal Hospital and establishing a unit to serve the Grace and Misericordia populations. This action would be impractical.

3a(2i) Recommendation:

There should be three palliative care units of approximately 24 beds in Winnipeg: Health Sciences Centre, Municipal and St. Boniface. The unit at Health Sciences Centre might serve Seven Oaks as well as its own patients. The unit at the Municipal Hospital could serve Victoria, Misericordia and Grace Hospitals. The unit at St. Boniface might serve Concordia as well as its own patients. The unit at the Assiniboine Centre should continue as it exists.

3a(2ii) Urban Home Care:

Home care services should be augmented by a float pool of nurses prepared for caring for the terminally ill patients by attending in the patient's home on a one to one basis at the very end stage of terminal illness. Such a pool could be established in relation to nursing organizations such as the Victorian Order of Nurses and/or Continuing Care. Existing policies regarding level of preparation would need re-examination to ensure that an appropriate person was placed in the home without requiring higher levels of preparation than would actually be needed. This would reduce hospital use by facilitating care at home.

3a(2iii) Standard Procedures Recommended:

a) Referral would come from the patient's family physician.

b) Admission to the palliative care program would give access to specialized services at home, particularly the float pool prepared nurses referred to in Recommendation 3a(2ii) above. The hospitals identified for palliative care units already have home care programs experienced in the co-ordination of community care. The additional load of specialized palliative cases would require some additional nursing staff in the home care offices.

c) Admission to the palliative care program would assure access to ready hospital admission either to a palliative care unit to a hospital ward identified for the purpose with beds reserved for palliative care.

3a(2iv) Medical Staffing:

In the suggested 24 bed Winnipeg palliative care units, three equivalent full time physicians per unit would be required for the in-patient responsibilities, the consulting services and home visiting.

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3a(2v) Hospice:

There is one aspect of palliative care which now uses hospital care more than really necessary. The terminally ill patient whose condition is stable but who has no family to provide care might not need to be in hospital but virtually never lives long enough to transfer to a personal care home. The palliative care unit at St. Boniface Hospital has made a rough estimate that census could be reduced from the present 24 to 19 or 20 if short stays out of hospital (a few weeks to a few months) could be readily arranged for this category of patient. A specialized home with some professional nursing care on a visiting basis and with volunteers might prove acceptable to patients and less costly than hospital, presuming the patient would pay a daily charge comparable to personal care homes. The Manitoba Palliative Care Foundation and Jocelyn House are interested in an opportunity to sponsor such a development.

Recommendation:

A minimal care residential facility, as described, is recommended providing it is large enough to be staffed economically, probably more than 20 residents.

3a(2vi) Day Hospital:

There are existing day programs for geriatrics at Municipal and St. Boniface Hospitals. Since most of the deaths of cancer patients are in the 60+ group these patients would fit into the existing programs if the programs were supplemented with one or more additional staff members educated in palliative care. Such a service could start as a pilot project linked with either of the current programs. Both geriatric day hospitals now have excess physical capacity and are waiting for staffing budgets to increase provision of services.

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3b. Staff Preparation

The technical side of palliative care is relatively simple, largely involved with control of symptoms. The more difficult part is giving up curative expectations and the style of communication appropriate to those expectations, concomitant with adopting goals, expectations and communication which are realistic, humane and appropriate to terminal illness. This involves what might be called re-acculturation. At St. Boniface, new staff is trained with minimal didactic material; the principle method is participating in a "buddy" or apprentice relationship with one's own profession; the role modelling is always enriched by team dialogue: participating in a perpetual behavioural and semantic environment in which death is accepted as a fact of life, in which one helps "medically" in the ways which are possible (interpreting illness and controlling symptoms) and an environment in which the main objective is not disease centred but person centred: how can we help this person live better, or least badly in little time? and ease bereavement? This preparation takes about three months but it is believed that two weeks would give good preparation for staff who would then move on to a setting where continuing experience would sustain the revised approach to the terminally ill patient and family.

The existing palliative care units already offer inservice experience for nursing, social work, pastoral care, rehabilitation therapy and medicine. These could be expanded at little cost. (See St. Boniface Hospital Proposal - Appendix VIII).

There also exists in Manitoba a Palliative Care Interest Group which meets regularly to bring together prefessionals in this area for continuing education and mutual support. (Contact Palliative Care Unit, St. Boniface General Hospital).

CONCLUSION

Three recommendations are made for the care of the terminally ill:

1. Improve the recogniation of those patients who are terminally ill in order to offer appropriate treatment by encouraging the College of Physicians & Surgeons to develop and review standards of practice in this area.

2. Improve patient autonomy with regard to acceptance and refusal of treatment by encouraging the Manitoba Health Organization, through hospital boards, to establish practices which enhance the autonomy of patient and family.

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3. Improve alternative services for the terminally ill, mainly for cancer patients, by encouraging the redesignation of hospital beds to establish more palliative care units on the model of existing units, and utilizing existing units to prepare professional staff for appropriate care of the terminally ill.

3a. Designate four palliative care units in Manitoba: 24 beds units at the Health Sciences Centre, the Municipal Hospital and the St. Boniface General Hospital and a 12 bed unit at the Assiniboine Centre. In rural hospitals and urban hospitals without palliative care units permit participation in the palliative care program by a hospital's indication of willingness to protect beds for the admission of terminally ill patients and by arranging appropriate preparation of staff on wards where beds will be used for the terminally ill. Palliative care should be based on a formal link, initiated by the primary physician, co-ordinated by the home care program and backed up by assured admission, in crisis, to an identified facility, either a palliative care unit or a hospital ward.

3b. Augment urban home care services with a new category of home care nursing: a float pool of nurses to provide continuous attendance at the dying patient's home during the last hours of life.

3c. Establish a hospice for stable terminally ill patients who do not have a home in which to be cared for.

3d. Broaden the scope of existing geriatric day hospital programs to cover the terminally ill; begin with a pilot program at the Municipal Hospital or St. Boniface General Hospital

APPENDIX I

HOSPICE OR PALLIATIVE CARE:

Terminology

Hospice and Palliative care are roughly equivalent. "Hospice" derives from St. Christopher's Hospice in London, England, a pioneer and model service for the care of the dying. It is a freestanding institution for the care of the dying. As a model it has inspired other services including home care, day care, out-patient clinics, hospital units and hospital consulting services, all using the term hospice to identify specialized care, appropriate to the dying patient and the patient's family: a "philosophy," style and technique of caring. The term "palliative" is used in Canada; it derives from the palliative care unit of the Royal Victoria Hospital in Montreal, a hospital in-patient unit, one of the first hospice services in Canada. Whichever term is used it may refer to any of the several forms of organization mentioned, often a combination of forms.

APPENDIX A

MANITOBA

MINISTER OF HEALTH
MINISTRE DE LA SANTÉ

WINNIPEG, MANITOBA
R3C 3R8

FEB 3 1984

Dear

I have requested David Pascoe, Director of the Research and Planning Directorate, to chair a Health Services Review Committee. The Review Committee will be established in February, 1984, to examine several critical health issues during the following five months. I ask that your institution participate in this important effort by appointing Mr. Gerry Hiebert.

The Review Committee will be comprised of approximately fifteen members from urban hospitals, rural hospitals, the College of Physicians and Surgeons, the University of Manitoba, the Manitoba Medical Association, the Manitoba Association of Registered Nurses, and senior government staff. The Review Committee is intended to function as a steering committee, striking sub-committees with expanded membership to review selected topics.

The terms of reference for the Review Committee are to examine current health issues and recommend future directions to the Minister of Health. Specific issues for review have not been defined for the Committee. The Committee will establish its own agenda. Examples of key topics include:

(a) hospital bed supply;
(b) ophthalmology services; and,
(c) alternatives to hospital admission.

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This listing is not intended to be exhaustive.

It is intended that members of the Review Committee meet twice per month. I have requested the Manitoba Health Services Commission to reimburse committee members for travel costs and other out-of-pocket expenses. I trust that sponsoring agencies will provide sessional fees for Review Committee members where necessary.

The suggested afternoon meeting schedule in the M.H.S.C. executive boardroom is as follows:

February 20
March 5, 19
April 2, 16
May 7, 22
June 4, 18

The secretarial/support services will be provided by the Research and Planning Directorate. If you have any questions, please contact the Chairman of the Review Committee, David Pascoe, at 772-7702; 206 - 1580 Dublin Avenue, Winnipeg, R3E 0L4.

Please notify Mr. Pascoe of your decision to participate on the Review Committee. I wish to thank you in advance for your anticipated co-operation.

Yours sincerely,

ORIGINAL SIGNED BY
L. L. DESJARDINS

L. L. Desjardins

APPENDIX B

ADMINISTRATIVE IMPACTS SUB-COMMITTEE

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Mr. N. Kalansky
Mr. D. Krack, Recording Secretary
Mr. G. Chapman
Mr. A. Hiebert
Mr. P. Pauls

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Dr. C. Cameron
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Dr. C. Unruh

APPENDIX C

MANITOBA

MINISTER OF HEALTH
MINISTRE DE LA SANTÉ

WINNIPEG, MANITOBA
R3C 3R8

JUN 14 1984

Dear

Recently, I requested several organizations[1] to participate in a review of Manitoba's health services. Representatives have been selected for this Health Services Review Committee to consider immediate issues such as cost constraint and future issues such as structures for health service delivery. The Health Services Review Committee intends to use the services of several sub-committees to investigate particular topics which require analysis and review. I appreciate your interest to participate as a sub-committee chairman.

The deliberations of the sub-committees are to take into account:

a) the maintenance of efficacious health care;

b) the acceptance of prudent fiscal restraint; and,

c) the projected increased demand for health services brought about by the anticipated increase in the number of elderly.

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[1] Manitoba Medical Association; Misericordia General Hospital; College of Physicians and Surgeons; Rural Hospital (Portage); Health Sciences Centre; Social and Preventive Medicine; University of Manitoba; St. Boniface General Hospital; Manitoba Association of Registered Nurses.

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Alternatives to be considered include a shift in focus from inpatient treatment to treatment on a day patient basis. This mode of treatment assumes an appropriate level of home health services to provide adequate support and/or alternative care in the patient's home. Also to be considered are current patterns of utilization of inpatient beds and the allocation of the required number of inpatient beds. Consideration will be given to the designation of certain specialty programs as provincial health care programs, with the appropriate allocation of resources to meet demonstrated patient needs. This overall review will include patient utilization in both urban and rural areas.

Given this context, I suggest that each sub-committee undertake its review within its terms of reference while taking into account the province's fiscal constraints. While government may be able to consider alternative types of services, the previous pattern of extensive service expansion will not likely re-occur in the foreseeable future. Rather than impose unilateral resource allocation, we have chosen to consult with key experts in the industry.

To focus the activities of all sub-committees, I provide the following terms of reference that are consistent with the Health Services Review Committee's mandate:

1) Each sub-committee will be requested to identify current and new categories of disease/treatment for which there is no alternative to hospitalization. Anticipating trends for the next decade for such categories may be based upon local experience and literature.

2) Each sub-committee will be requested to identify current and future categories of disease/treatment for which there are alternatives to traditional hospitalization. Recommendations for means to achieve the goal of increased out-of-hospital diagnosis/treatment will be welcomed. For each proposed change, the sub-committee will be requested to estimate the impact upon the quality of health care available in the future.

3) Although time is short, I would hope that sub-committees will be in a position to report to the Health Services Review Committee by September 30, 1984.

While the Health Services Review Committee may have suggested the names of some members for your sub-committee, please feel free to suggest additional membership that you feel appropriate (e.g. rural,

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physician, nursing, and other allied specialist representation). To elicit the cooperation and coordination necessary to bring together the variety of health care professionals you will have in support of the work of your sub-committee, please send your list of proposed sub-committee members to David Pascoe, Chairman of the Health Services Review Committee, 308 - 294 Portage Avenue, Winnipeg, Manitoba, R3C 0B9. Mr. Pascoe will confirm the membership of the sub-committee with the Health Services Review Committee. At least one member of the Health Services Review Committee will participate on each sub-committee to provide continuity. Professional support services to sub-committees will be provided (e.g.-minutes and data collection) by staff members of the Manitoba Health Services Commission or the Department of Health.

To begin the process, I will convene a seminar on June 19, 1984, 9:00 a.m. - 12:00 p.m., for all sub-committee chairmen to consider economic, population, and service delivery variables. Each sub-committee will be provided with information to serve its needs. Enclosed is an agenda for this seminar.

I thank you for your interest in participating in this important review process. The task before us is challenging and I am certain that the benefits that will accrue to Manitobans and the health care industry will be most rewarding. I look forward to the results of the review process.

Yours sincerely,

ORIGINAL SIGNED BY
L. L. DESJARDINS
L. L. Desjardins

Enclosure

POOR
QUALITY
ORIGINAL